

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1765

Items 18-21 Film 383 11- MARYLAND: STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12843

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8704 Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8704 Gilbert Place Apt 1-B</u>				d. STREET ADDRESS <u>8704 Gilbert Pl Apt 1-B</u>			
3. NAME OF DECEASED (Type or print) <u>Leonard Daniel Adams</u>				4. DATE OF DEATH <u>Sept 9 1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1924</u>	9. AGE (In years lost birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Daniel Adams</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war in which served) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Evelyn Oarrow</u> Address <u>8214 1st Pl S.W. Spg Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>870.0</u> IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to</u> DUE TO (b) <u>Overdosage of narcotics</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deceased apparently took overdose of morphine, heroin, or both.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased apparently took overdose of morphine, heroin, or both.</u>			
20c. TIME OF INJURY Month, Day, Year <u>12 noon 9-9 19 66</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		23b. DATE THEREOF <u>Sept 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Burham, North Carolina</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> ADDRESS <u>434 Ga. Avenue</u>				25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

1941

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12849

12844

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TOWN 30 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 18830 Chandlee Mill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle Gwendolyn Last Addison		4. DATE OF DEATH Month 9 Day 21 Year 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/36
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel C. Gaither		14. MOTHER'S MAIDEN NAME Mattie Lockman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA + /NANITION DUE TO (b) ACUTE + CHRONIC OSTEOMYELITIS (c) GANGRENE (NECROSIS) OF PELVIS		INTERVAL BETWEEN ONSET AND DEATH 3 WKS 6-8 WKS 4 WKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARAPLEGIA - MARKED DECUBITAL ULCERATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/9/66 , 19 66 , to 9/21/66 , 19 66 , that (I) (we) last saw the deceased alive on 9/21/66 , 19 66 , and that death occurred at 9:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Donald R. Lewis		22b. DATE SIGNED 9/21/66	
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis		22d. ADDRESS OLNEY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1		23b. DATE THEREOF 9-25-66	
23c. NAME OF CEMETERY OR CREMATORY t. Zion.,		23d. LOCATION (City or Town) (County) (State) Mt. Zion, Md.	
24. FUNERAL DIRECTOR George R. Snowden Rockville		25a. REC'D BY REGISTRAR DATE SEP 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

CASE DISCUSSED & CLEARED WITH MED. EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12850

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12845

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 2914 Lindell Ct.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Virginia Middle Mary Last Austin			4. DATE OF DEATH Month September Day 26 Year 19 66		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1895	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 7 Days 15 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joshua Thomas Austin			14. MOTHER'S MAIDEN NAME Martha E. Talbott		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Brother Address Thomas T. Austin Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread metastatic carcinoma 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of large bowel DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 66 , to 9-26 , 19 66 , that (I) (we) last saw the deceased alive on 9-26 19 66 , and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE James H. Scully			22b. DATE SIGNED 9-26 66		
22c. PHYSICIAN'S NAME (Type) James H. Scully			22d. ADDRESS 1835 Eye St N.W. Washington, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-28-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town or county) (State) Bethesda, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR SEP 27 1966		
			25b. REGISTRAR'S SIGNATURE John D. Judge		

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Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7221 Minter Pl</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN + HOSP</u>		d. STREET ADDRESS <u>Takoma Park Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET HELEN BARG HAUSEN</u>		4. DATE OF DEATH <u>9 / 10 / 1966</u>	
5. SEX <u>F</u> 6. COLOR OR RACE <u>Wh</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/96</u> 9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John ORR</u>		14. MOTHER'S MAIDEN NAME <u>Ellen McGillicutty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Intracerebral Hem. rt. vent.</u> DUE TO (b) <u>Cerebral Hem. rt. vent.</u> DUE TO (c) <u>Chronic Hypertension - decamp</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9/6/66</u> <u>9/1/66</u> <u>8/12/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1965</u> to <u>Sept 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>66</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Howard I Morse</u>		22b. DATE SIGNED <u>9/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard I Morse MD</u>		22d. ADDRESS <u>3030 Carroll Takoma Park Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Prince Georges Md</u>	
24. FUNERAL DIRECTOR <u>William J. Talley</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12852					12847				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Montgomery</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>5904 Onondaga Rd.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Nursing Home</u> <u>3000 McComas Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>s</u> Middle <u>Barker</u> Last					4. DATE OF DEATH <u>Sept. 28</u> Month <u>19</u> Day <u>66</u> Year				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/83</u>		9. AGE (in years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George C. Barker</u>					14. MOTHER'S MAIDEN NAME <u>Lucy E. Lambert</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>579-05-2897</u>		17. INFORMANT <u>Claire S. Adams</u> Address <u>same as #2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary heart failure</u> <u>4200</u> DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 wks</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>66</u> , to <u>Sept 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> , 19 <u>66</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>9/28/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>					22d. ADDRESS <u>7852 16th St NW Wash DC</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>9/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>					25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
					DATE <u>OCT 3 1966</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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12848

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first last and residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>TAKOMA PARK</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY N 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Montgomery County Hospital</u>		d STREET ADDRESS <u>709 Auburn Ave.</u>	
3 NAME OF DECEASED (Type & print) First Middle Last <u>Female</u> <u>Campanian</u> <u>AAA</u>		4 DATE OF DEATH Month Day Year <u>2-17-66</u> 19 <u>66</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-21-95</u>
9a USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Housewife</u>		9b KND OF BUSINESS OR INDUSTRY	
10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Housewife</u>		10b KND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>NEW YORK</u>		12 CITIZEN OF WHAT COUNTRY? <u>American</u>	
13 FATHER'S NAME <u>NATHAN RUDOLF</u>		14 MOTHER'S MAIDEN NAME <u>IDA FISHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>42-17-95</u>	
17. INFORMANT <u>SA</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRCULATORY COLLAPSE</u> (c) <u>PERIPNEUMONIC PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTHYROIDISM & A.S.H.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-27, 1966</u> , to <u>9-16, 1966</u> that (I) (we) last saw the deceased alive on <u>9-16, 1966</u> and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Gilbert B. Cushman</u>		22b DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHMAN</u>		22d ADDRESS <u>2424 E. 11th St. N.W.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>9-18-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>E.C. Lookey Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24 FUNERAL DIRECTOR <u>Kolbier, F.H. 4217-9th St. N.W.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 19 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 11200 Lockwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Portia Middle Imogene Last Ross
4. DATE OF DEATH Month Sept. Day 13 Year 1966

5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec. 28, 1886 9. AGE (In years last birthday) 79 yrs. 10. IF UNDER 1 YEAR, UNDER 24 HRS. Months 1 Days 10 Hours 10 Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Henry W. Moran 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 577-03-62708 17. INFORMANT Roscoe H. Buss Address 11200 Lockwood Dr. Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia due to nephrosclerosis 10 days
DUE TO (b) Coronary Heart Failure 10 days
DUE TO (c) Myocardial Infarction 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) Essential Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

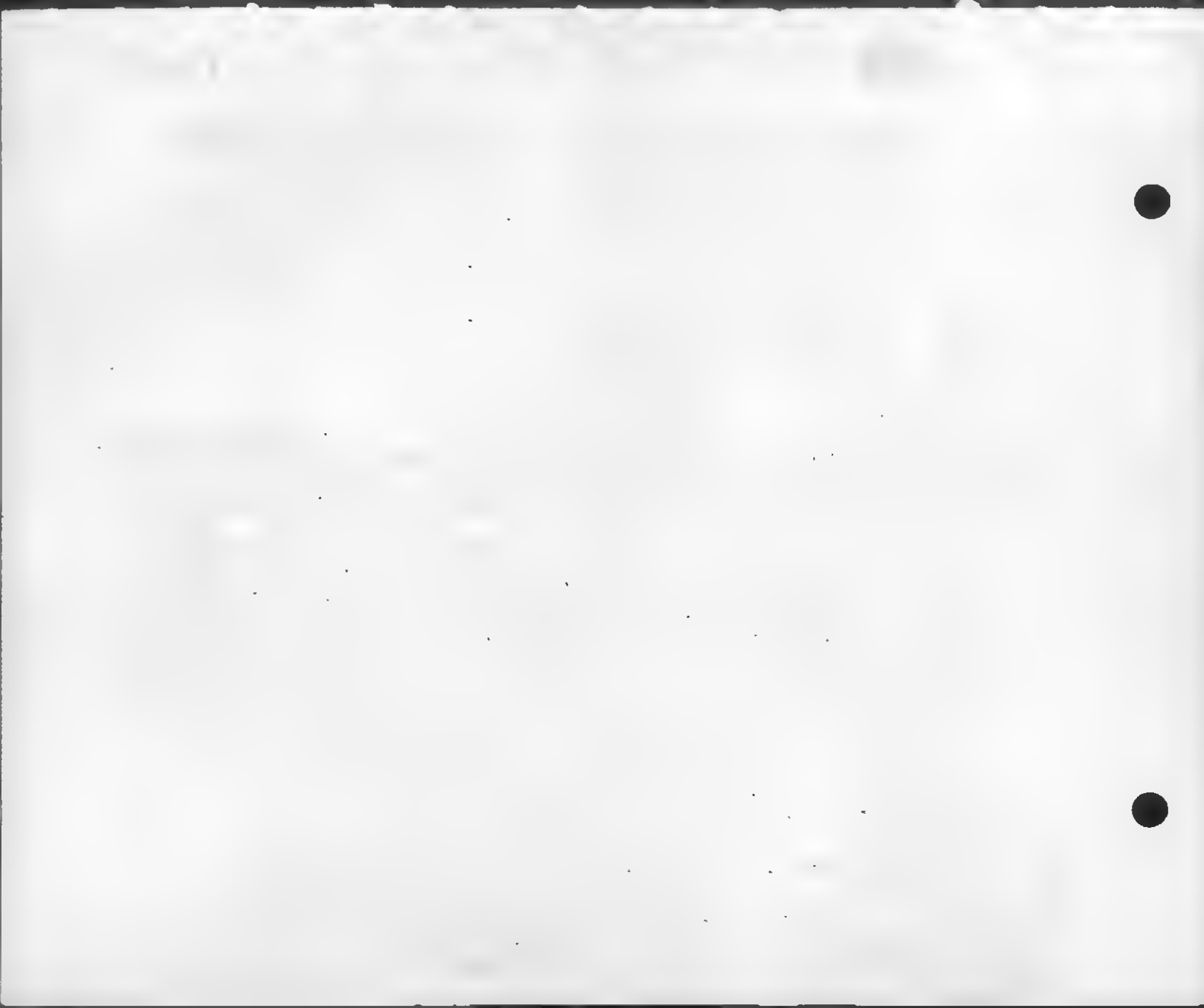
20c. TIME OF INJURY Month, Day, Year Sept 13, 1966 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Silver Spring (County) Montgomery (State) Md.

21. I certify that (I) (this hospital) attended the deceased from Sept 13, 1966, to Sept 23, 1966, that (I) (we) last saw the deceased alive on Sept 23, 1966, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE John J. Curry M.D. 22b. DATE SIGNED 9/23/66
22c. PHYSICIAN'S NAME (Type) John J. Curry, M.D. 22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 27, 1966 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. 23d. LOCATION (City, town or county) Arlington, Virginia (State) Virginia

24. FUNERAL DIRECTOR Glen Carter ADDRESS 834 Georgia Ave. Silver Spring, Md. 25a. REC'D BY REGISTRAR SEP 27 1966 25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

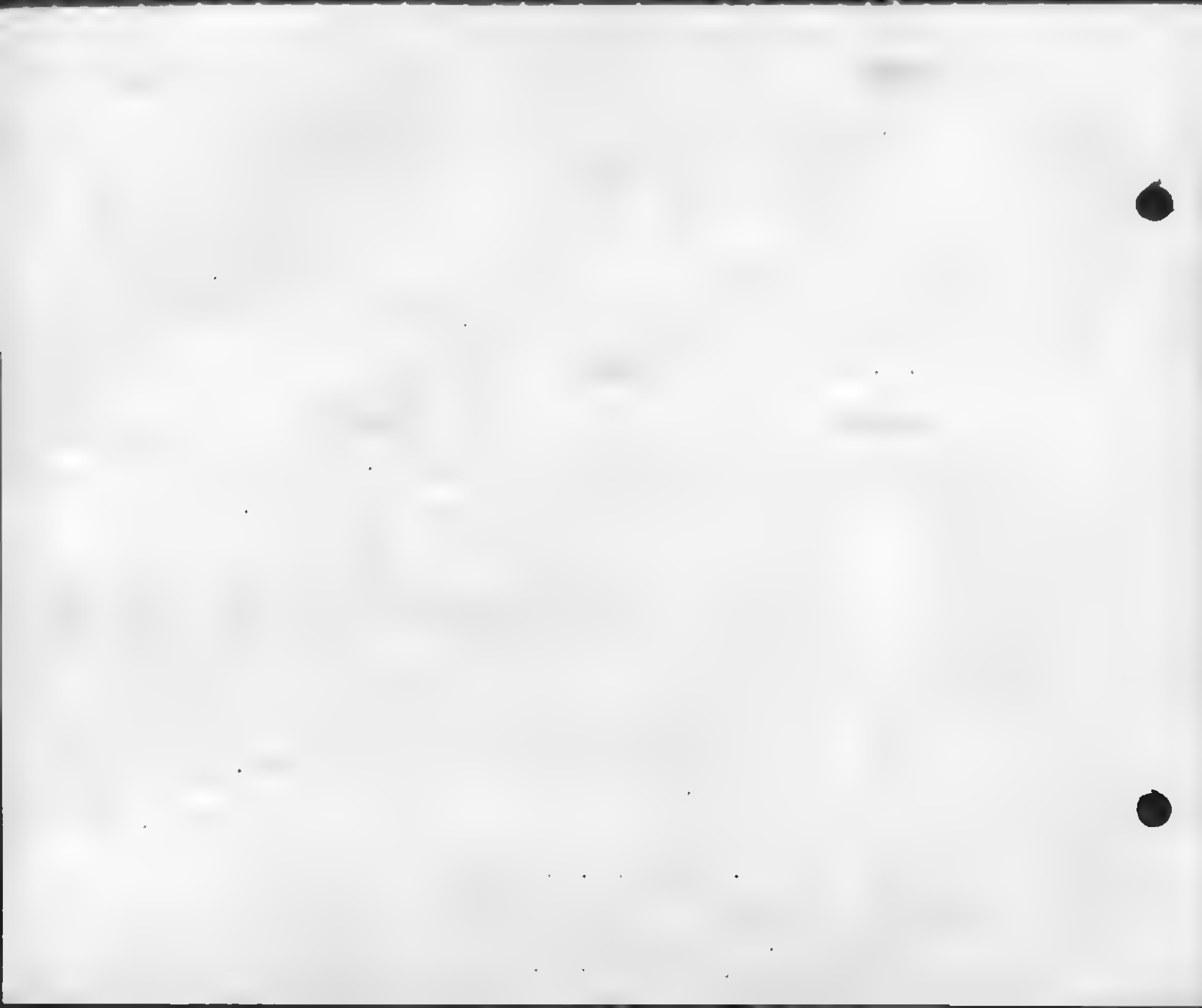
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12855

CERTIFICATE OF DEATH

12850

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN It 12 days	c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		e. STREET ADDRESS 98 Conduit Street	
3 NAME OF DECEASED (Type or print) First Wilburn Middle BATES Last BATES		4 DATE OF DEATH Month Sept. Day 20 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1886
9. AGE (in years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY BETO	
11 BIRTHPLACE (County & State or foreign country) Tennessee		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME (UWK)		14 MOTHER'S MAIDEN NAME (UWK)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes 1910-1946		16. SOC. A. SECURITY NO.	
17 INFORMANT Norwood Mr. Wilburn E. Bates, 105 Trites Ave.		Address Pennsylvania	
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell carcinoma of the oral mucosa with widespread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) 1111 DUE TO (c) 1111 DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospita) attended the deceased from Aug. 8 , 19 66 , to Sept. 20 , 19 66 that (X) (we) last saw the deceased alive on Sept. 20 , 19 66 , and that death occurred at 650PM , from causes and on the date stated above			
22a. SIGNATURE Robert W. Cantrell M.D.		22b. DATE SIGNED Sept. 21, 1966	
22c. PHYSICIAN'S NAME (Type) Robert W. CANTRELL, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMAT. OR REINTERMENT (Specify) Burial	23b. DATE THEREOF 9-23-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR John M. Taylor Funeral Home 147-149 Gloucester St., Annapolis, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 1966	
25b. REGISTRAR'S SIGNATURE			



1255
Reg. Dist. No.

CERTIFICATE OF DEATH

1255
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If first listed on Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 720 DARTMOUTH AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) R.D. LF		4. DATE OF DEATH Month SEPT Day 8 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 23, 1877
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARTIST		10b. KIND OF BUSINESS OR INDUSTRY MR. CARPARKS	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM CURTIS DALLS		14. MOTHER'S MAIDEN NAME BERTHA ECKHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 578-46-8	
17. INFORMANT MRS. CAROL BAUSS		Address 5150 SPRING	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC DUE TO BRONCHITIS, CARCINOMA & METASTASIS DUE TO 7 MINS.		INTERVAL BETWEEN ONSET AND DEATH 7 MINS.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -	
20c. TIME OF INJURY: Month, Day, Year Hour a. m. p. m. - 19		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from SEPT 8, 1966 , to SEPT 8, 1966 , that I last saw the deceased alive on SEPTEMBER 7, 1966 , and that death occurred at 9:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 911 SILVER SPRING AVE., SILVER SPRING, MD 20910 DATE SIGNED SEP 8 1966 ACTUAL SIGNATURE Harold W. Draper M.D. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-10-66	
22c. NAME OF CEMETERY OR CREMATORY National Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Chillicothe, VA	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Hooten		24a. REC'D BY REGISTRAR SEPT 11 1966	
ADDRESS 3821-14th St NW, Wash. DC		24b. REGISTRAR'S SIGNATURE Charles Judge	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

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1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12552

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE Where deceased lived, if institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY N 16 <u>5 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>1935 Kimberley Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Gregory Richard Becker</u>		4 DATE OF DEATH <u>Sept. 2, 1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-5-51</u>
9 AGE (In years last birthday) <u>15</u> yrs		10 FUND 1 YEAR Months Days FUND 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph J. Becker</u>		14 MOTHER'S MAIDEN NAME <u>Meadows, Mildred C</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>—</u>		Address <u>—</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain Stem Lesion</u> DUE TO (b) <u>—</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>April 4, 1966</u> , to <u>Sept 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 2, 1966</u> , and that death occurred at <u>2:40</u> PM, from causes and on the date stated above			
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u> M.D.		22b. DATE SIGNED <u>Sept. 2, 1966</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept 6 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24 FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>SEP 7 1966</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

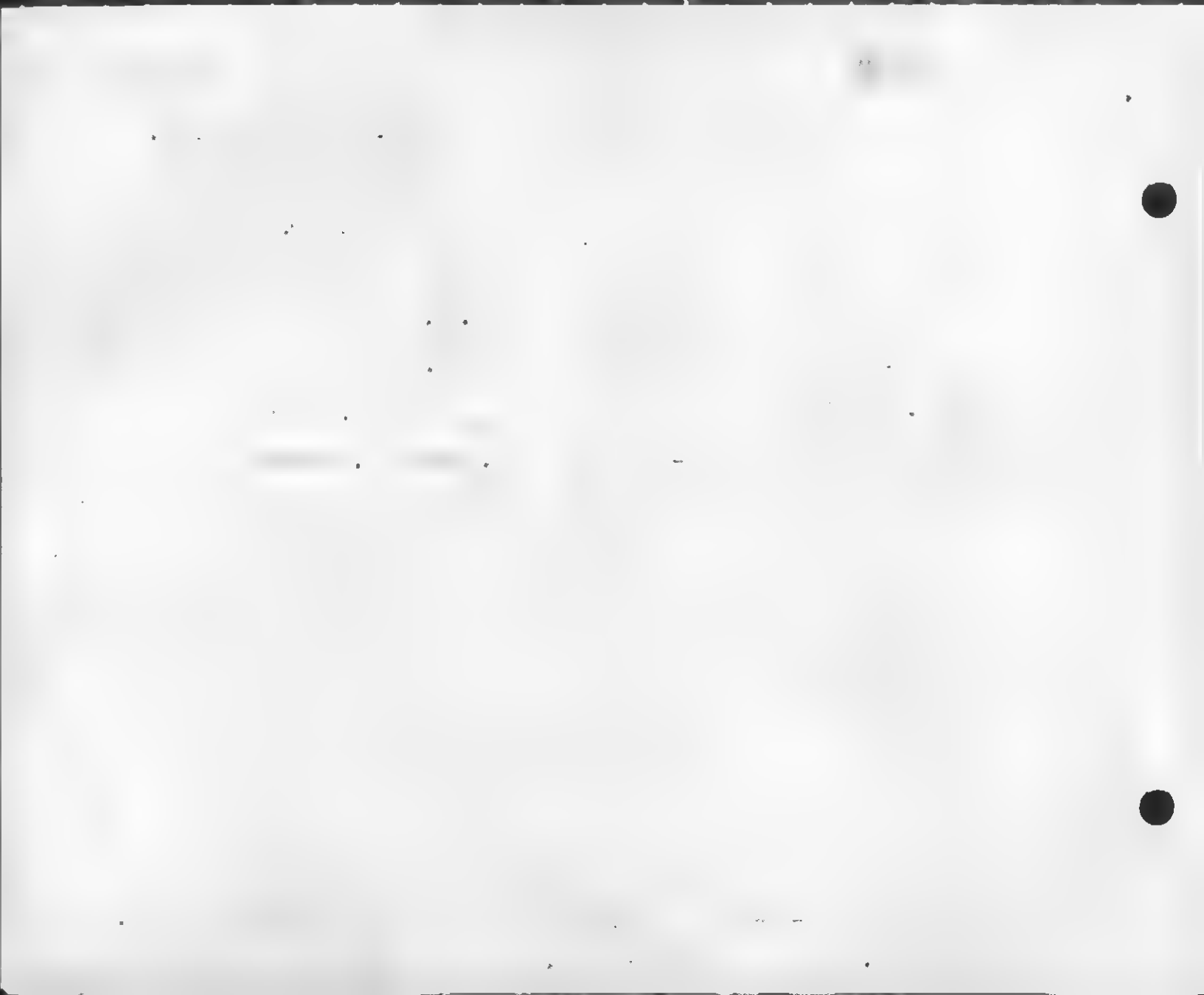
12853

58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Mont.</u>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c LENGTH OF STAY IN "b" <u>5 min.</u>	c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ashton</u>
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>		d STREET ADDRESS <u>900 Ashland Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>Alice Camalier Behrendt</u>		4 DATE OF DEATH <u>September 22, 1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 4, 1890</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. Wife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (in years last birthday) <u>76</u> yrs
11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John V. Camalier</u>		14 MOTHER'S MAIDEN NAME <u>Alice T. Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17 INFORMANT <u>Mr. Norbert L. Behrendt</u>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>50 yrs</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>50 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> to <u>9/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/22</u> , 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above			
22a SIGNATURE <u>C. H. Barber</u>		22b DATE SIGNED <u>9/23/66</u>	
22c PHYSICIAN'S NAME (Type) <u>C. H. Barber</u>		22d ADDRESS <u>Sandy Spring Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9-24-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	23d LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a REC'D BY REGISTRAR <u>SEP 23 1966</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b REGISTRAR'S SIGNATURE <u>John L. Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

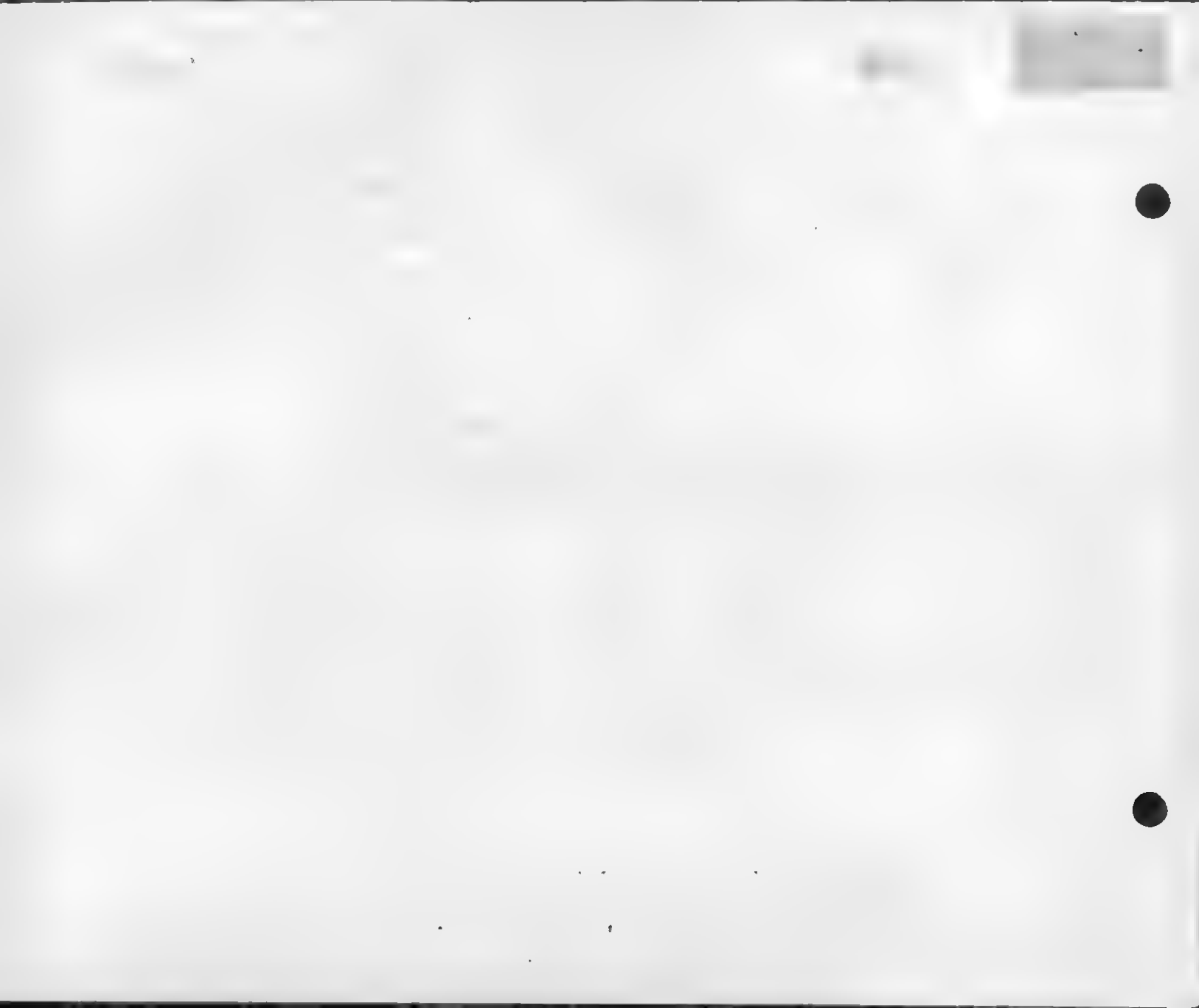
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Rhode Island b. COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 12 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital,		d STREET ADDRESS 12 Division Street	
3 NAME OF DECEASED (Type or print) First Middle Last Elizabeth Ellen BENJAMIN		4 DATE OF DEATH Month Day Year Sept. 22 19 66	
5 SEX Female	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 17, 1966
9 AGE (In years last birthday) yrs 36		IF UNDER 1 YEAR Days 36	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b KIND OF BUSINESS OR INDUSTRY N/A	
11 BIRTHPLACE (County & State, or foreign country) Newport, Rhode Island		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Richard Benjamin		14 MOTHER'S MAIDEN NAME Anna Pronti	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N/A		16 SOCIAL SECURITY NO N/A	
17 INFORMANT Newport, Rhode Island		Address Island Mrs. Richard Benjamin, 12 Division St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from Sept. 10, 1966 , to Sept. 22, 1966 that (2) (we) lost saw the deceased alive on Sept. 22, 1966 , and that death occurred at 1210M , from causes and on the date stated above			
22a SIGNATURE <i>Jerry J. Tomasovic</i>		22b DATE SIGNED Sept. 23, 1966	
22c PHYSICIAN'S NAME (Type) JERRY J. TOMASOVIC M.D.		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-24-66	23c NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	23d LOCATION (City or town) (County) (State) Horsehead, New York
24 FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland		25a REC'D BY REGISTRAR DATE SEP	25b. REGISTRAR'S SIGNATURE



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VR A1B (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12855

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		d STREET ADDRESS <u>Takoma Park</u> <u>7903 Lockney Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Chaim</u> <u>Berlin</u> <u>1</u>		4 DATE OF DEATH Month Day Year <u>9</u> <u>29</u> <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/25/1903</u>
9 AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11 BIRTHPLACE (County & State or foreign country) <u>Poland</u>	12 CITIZEN OF WHAT COUNTRY? <u>Poland</u>
13 FATHER'S NAME <u>Chaim Berlin</u>		14 MOTHER'S MAIDEN NAME <u>Chana Silverstone</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>4-14-11111</u>	
17 INFORMANT <u>MRS. Gussie Berlin - wife as above</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic Cardio-Vascular disease</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> to <u>Sept 29</u> , 19 <u>66</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Sept 24</u> 19 <u>66</u> , and that death occurred at <u>730 A</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Robert Kramer</u> M.D.		22b DATE SIGNED <u>9/29/66</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d ADDRESS <u>8484 16th ST. S.S. Rd.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>10-2-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD.</u>
24 FUNERAL DIRECTOR <u>Isampsky (C) Inc</u>		25a REC'D BY REGISTRAR <u>3501-14th St NW</u>	25b REGISTRAR'S SIGNATURE <u>SEP 29 1966</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12851

12856

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 4202 Hollin Ferry Rd.	
3 NAME OF DECEASED (Type or print) First James Middle Lee Last BERRY		4 DATE OF DEATH Month September Day 22 Year 1966	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 13, 1937
9 AGE in years (last birthday) 28 28^{rs}		10 IF UNDER 24 HRS Months 28 Days 28 Hours 28 Min 28	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Everett Berry		14. MOTHER'S MAIDEN NAME Pauline Withrow	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1955-1964		16. SOCIAL SECURITY NO. 520 40 5061	
17. INFORMANT Baltimore		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospita) attended the deceased from Sept. 22, 1966 , to Sept. 22, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 22, 1966 , and that death occurred at 630PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Francis C. Johnson</i> M.D.		22b. DATE SIGNED Sept. 23 1966	
22c. PHYSICIAN'S NAME (Type) F. C. Johnson, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-26-66	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Mt. Ranier		25a. REC'D BY REGISTRAR DATE	
ADDRESS Valley's Funeral Home, 3200 Rhode Island Ave./		25b. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

the funeral director. Page 4 should
5 may be retained for your files.

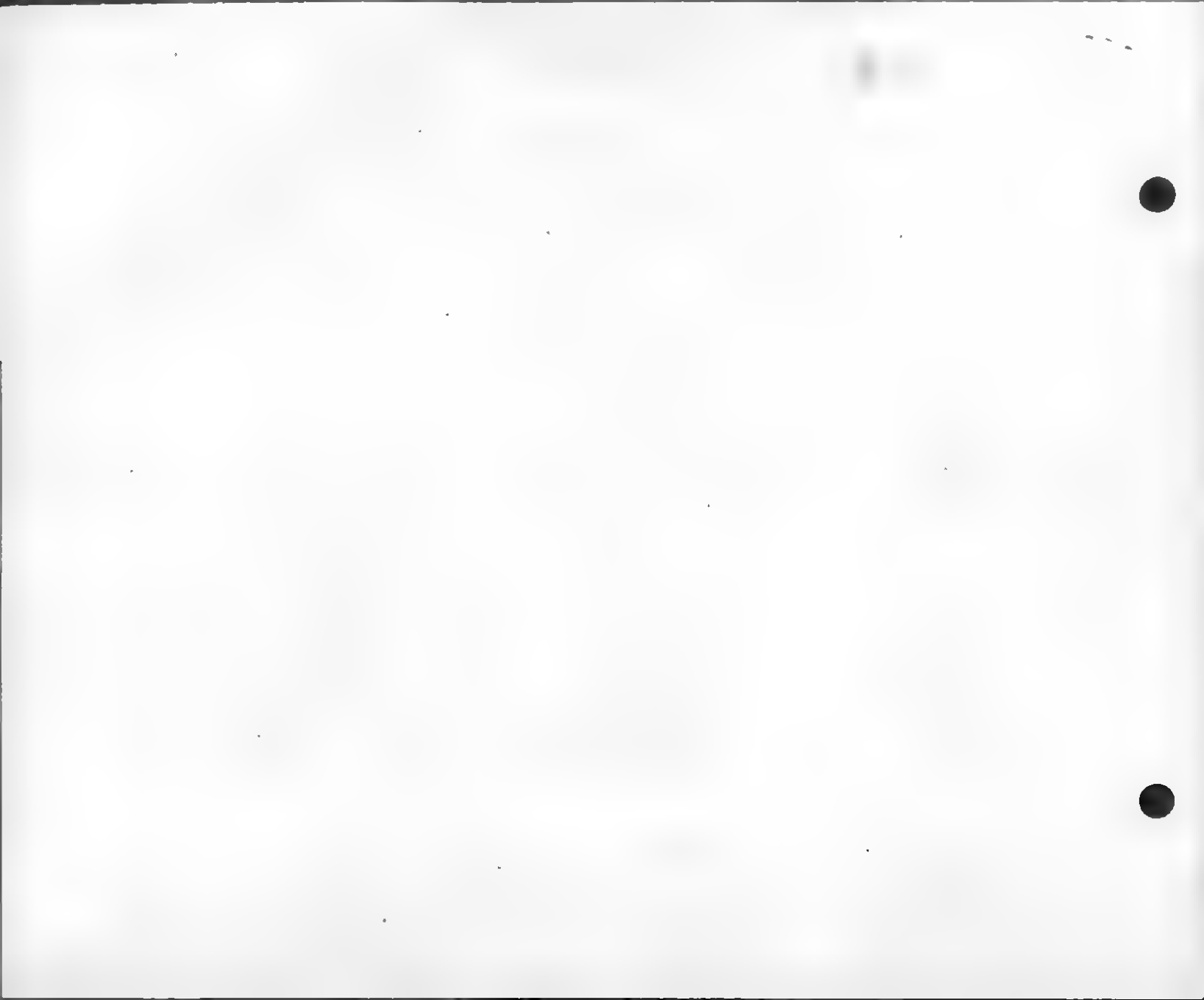
VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12857

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE "Where deceased lived if not in residence before admission" a STATE		b COUNTY	
b CITY OR TOWN If outside corporate limits write RURAL and give nearest town		c LENGTH OF STAY IN b		d CITY OR TOWN If outside corporate limits write RURAL and give nearest town	
e NAME OF HOSPITAL OR INS. INSTITUTION If not in hospital give street address		f STREET ADDRESS		g IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH		5 AGE years	
6 SEX		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH	
9 COLOR OR RACE		10 BIRTHPLACE State or foreign country		11 CITIZEN OF WHAT COUNTRY?	
12 FATHER'S NAME		13 MOTHER'S M maiden NAME		14 SOCIAL SECURITY NO	
15 WAS DECEASED EVER IN ARMY, AIR FORCE, NAVY, OR MARINE CORPS? If yes give war or date of service		16 INFORMANT		17 ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Barbiturate poisoning & Contusion</u> DUE TO <u>Trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>None</u> DUE TO (c) <u>None</u>		19 INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>		20 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		21c TIME OF INJURY Month, Day Year	
21d INJURY CORRECTED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		21e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		21f CITY OR TOWN (County) (State)	
22. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		24. DATE SIGNED	
25. ACTUAL SIGNATURE <u>John S. Rogers M.D.</u>		26. ADDRESS (Street, city, town, or county)		27. SIGNATURE <u>Sept 10, 1966</u>	
28a BURIAL, CREMATION, REINTERMENT (Specify)		28b DATE THEREOF		28c NAME OF CEMETERY OR CREMATORY	
28d LOCATION (City or Town) (County) (State)		28e REC'D BY REG. STRAR		28f REG. STRAR'S SIGNATURE	
29. FUNERAL DIRECTOR		30. ADDRESS		31. DATE	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1255

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (here deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>		d. STREET ADDRESS <u>9200 Rockville Pike</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Birdie</u> Middle <u>D</u> Last <u>Birch</u>		4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>8</u>	
11. IF UNDER 24 HRS. Hours <u>15</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Montgomery</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Cox</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-60-5500</u>	
17. INFORMANT <u>Marie H. Cotton-4418 McArthur Blvd. Washington D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Small hours</u> <u>15 yrs.</u> <u>15 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u> </u> to <u>present</u> , 19 <u> </u> , that (II) (we) last saw the deceased alive on <u>16 Aug</u> 19 <u>66</u> , and that death occurred at <u>5:45 P</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>14 Sept 66</u>	
22a. SIGNATURE <u>Charles E. Keegan Jr.</u>		22c. PHYSICIAN'S NAME (Type) <u>CHARLES E. KEEGAN JR MD</u>	
22d. ADDRESS <u>3752 BENTON ST NW Wash DC</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEP 17 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		23d. LOCATION (City, town or county) (State) <u>MARYLAND D.C.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Dwyer</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 10 1966</u>	

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VR 115 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown, Maryland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marylander Rest Home		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Washington, D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 827 Whittier Place N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle R. Last Black 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month Sept. Day 26 Year 1966 8. DATE OF BIRTH 7/20/1884 9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Roberts		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-44-2890	
17. INFIRMANT Martha J. Brosnan		Address 11609 Hitching Post Lane Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Paralysis agitans DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/22 , 19 56 , to 9/26 , 19 66 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 9/23 , 19 66 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS 26618 Ridge Road, Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF September 28, 1966	
23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION (City, town or county) (State) Martinsburg, West Virginia	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1931 Rockville Pike Rockville, Md.	
DATE SEP 28 1966		25b. REGISTRAR'S SIGNATURE SEP 28 1966	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

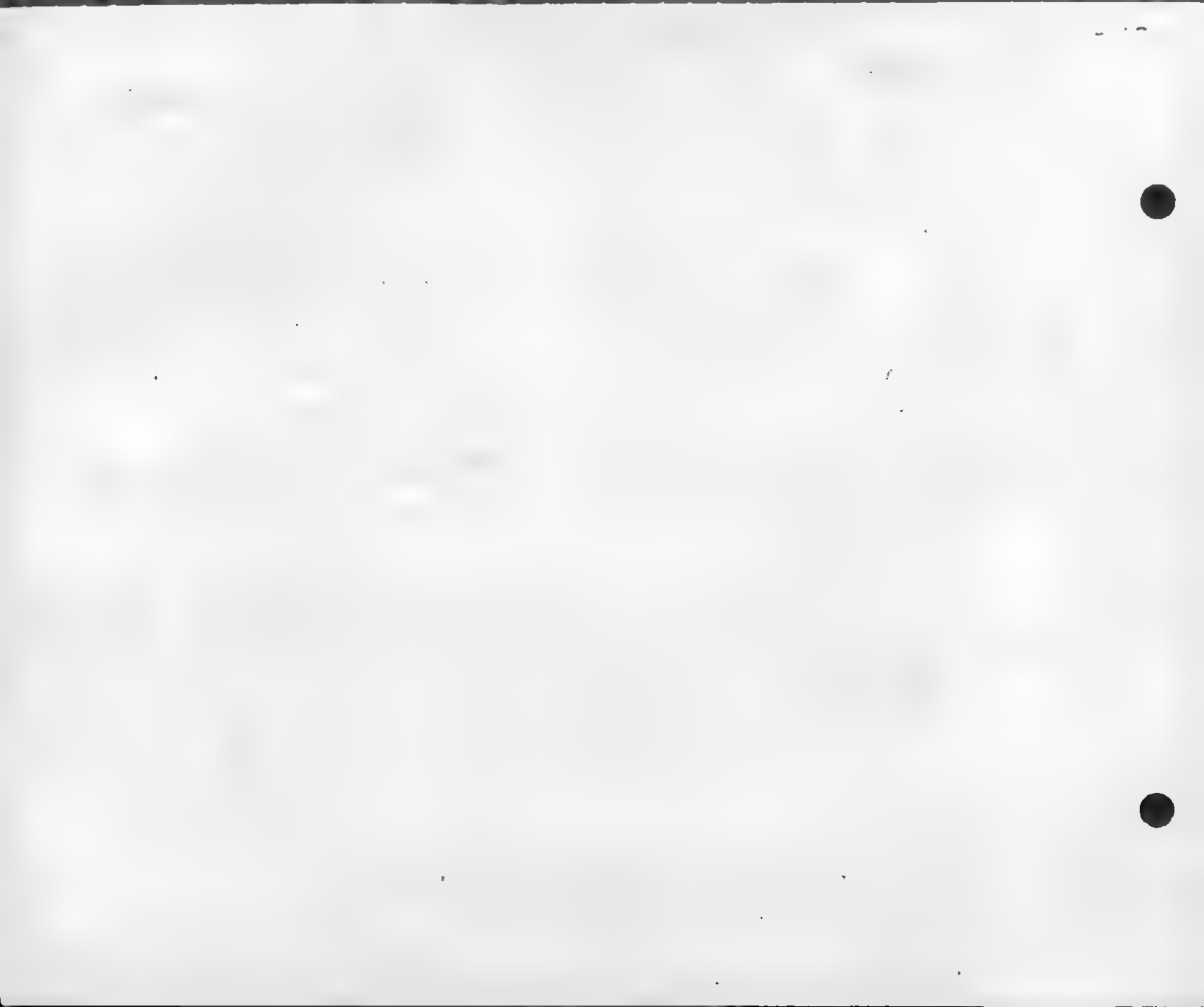
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c LENGTH OF STAY IN ID 19 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MICHAEL ALAN BLAND, Jr.		4 DATE OF DEATH Month Day Year SEPTEMBER 18 1966	
5 SEX MALE	6 COLOR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 13 AUG 1966
9a USUAL OCCUPATION Give kind of work done during most of working life, even if retired NA		9b KIND OF BUSINESS OR INDUSTRY NA	
10a BIRTHPLACE (County & State, or foreign country) MONTGOMERY, MARYLAND		10b CITIZEN OF WHAT COUNTRY? U.S.A.	
11 FATHER'S NAME MICHAEL ALAN BLAND		12 MOTHER'S MAIDEN NAME MAY VIRGINIA TAYLOR	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		14 SOCIAL SECURITY NO NA	
15 INFORMANT MICHAEL ALAN BLAND		Address 10819 BOSWELL LANE	
16 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PSEUDOMEMBRANOUS COLITIS, ASSOCIATED WITH PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 30 AUG 1966 to 18 SEP 1966 , that (I) (we) last saw the deceased alive on 18 SEP 1966 , and that death occurred at 5:00 PM , from causes and on the date stated above			
22a SIGNATURE <i>J. Tomasovic</i> M.D.		22b DATE SIGNED 18 SEP 66	
22c PHYSICIAN'S NAME (Type) J. TOMASOVIC, CAPT MC USAF		22d ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND	
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE THEREOF 9-21-66	23c NAME OF CEMETERY OR CREMATORY FARM LANE, INC.	23d LOCATION (City or Town) (County) (State) BETHESDA, MONTGOMERY, MD
24 FUNERAL DIRECTOR R.A. PUMPHREY		25a REC'D BY REGISTRAR SEP 1966	
25b REGISTRAR'S SIGNATURE <i>J. Pumphrey</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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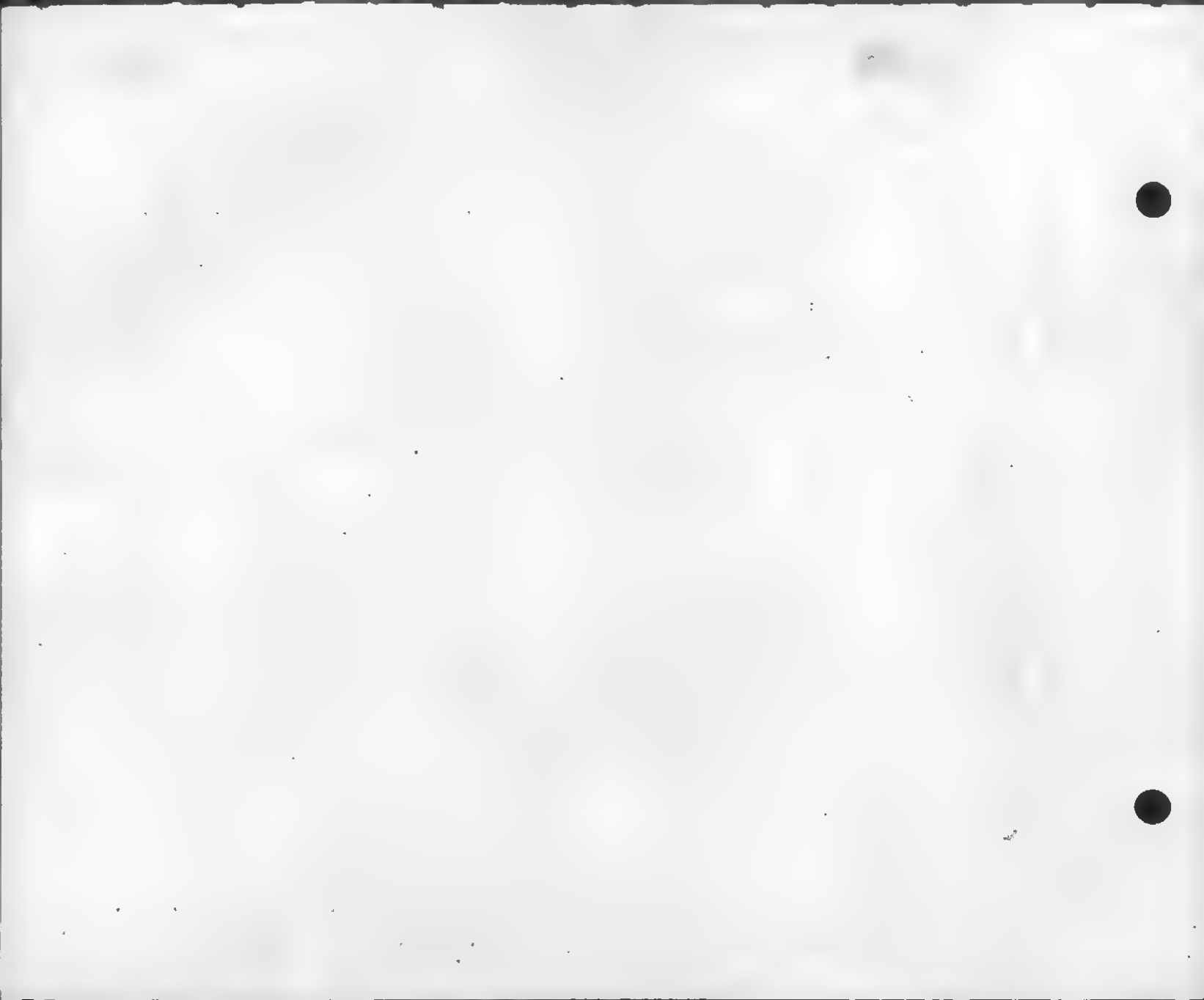
Carver Notified and will Appear

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12861

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Montgomery b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5480 Wisconsin Ave. Apt. 727				d. STREET ADDRESS 5480 Wisconsin Ave. Apt. 727			
3. NAME OF DECEASED (Type or print) First Edgar Middle Orville Last Blewett				4. DATE OF DEATH Month September Day 14 Year 1966			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/10	
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D.C. Government Inspector		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sanitation Engineer Walter Blewett				14. MOTHER'S MAIDEN NAME Clara Lucas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 567-20-4035		17. INFORMANT Violet B. Blewett	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-7- 19 54 , to 7-25 19 66 , that (I) (we) last saw the deceased alive on 7-25 19 66 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Louis Ross				22b. DATE SIGNED 9-14-66		22c. PHYSICIAN'S NAME (Type) Louis Ross	
22d. ADDRESS 1712 Eye St. N.W. Wash. D.C.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/19/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR The S.H. Hines Company				25a. REC'D BY REGISTRAR SEP 13 1966			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12-07

CERTIFICATE OF DEATH

12862

1 PLACE OF DEATH a COUNTY Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Oklahoma	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c LENGTH OF STAY N 1b 25 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) United Community Hospital		d STREET ADDRESS 202 N. Hill Street	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) Leslie Howard Block		4 DATE OF DEATH Month Sept Day 21 Year 1966	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/5/1922
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of business		10b KIND OF BUSINESS OR INDUSTRY Dry goods store	9 AGE (In years last birthday) 44 yrs
11 BIRTHPLACE (County & State or foreign country) New York City, N. Y.		2 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Leslie Howard Block		14 MOTHER'S MAIDEN NAME Ramin?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 44-059005-D	17 INFORMANT Howard Block 902 Newhall St. S.S.M. Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Fibrosarcoma of neck DUE TO (c) Adenocarcinoma of uterus			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of uterus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1964 to Sept. 21, 1966, that (1) (the) lost soul the deceased alive on 9/21/1966, and that death occurred at 11:30 PM, from causes and on the date stated above			
22a SIGNATURE Norman H. Rubenstein - M.D.		22b. DATE SIGNED 9/21/66	
22c PHYSICIAN'S NAME (Type) Dr. Norman Rubenstein		22d ADDRESS 140 New Hampshire Ave., N.W., Wash., D.C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9/25/66	23c NAME OF CEMETERY OR CREMATORY Waterbury Hebrew Cemetery	23d LOCATION (City or Town) (County) (State) Waterbury, Connecticut
24 FUNERAL DIRECTOR Bernard Danzansky & Sons		ADDRESS 3501-14th St. N.W., Wash. DC	25a REC'D BY REGISTRAR DATE SEP 26 1966
		25b REGISTRAR'S SIGNATURE John A. Judge	



FOR STATE
HEALTH DEPT.

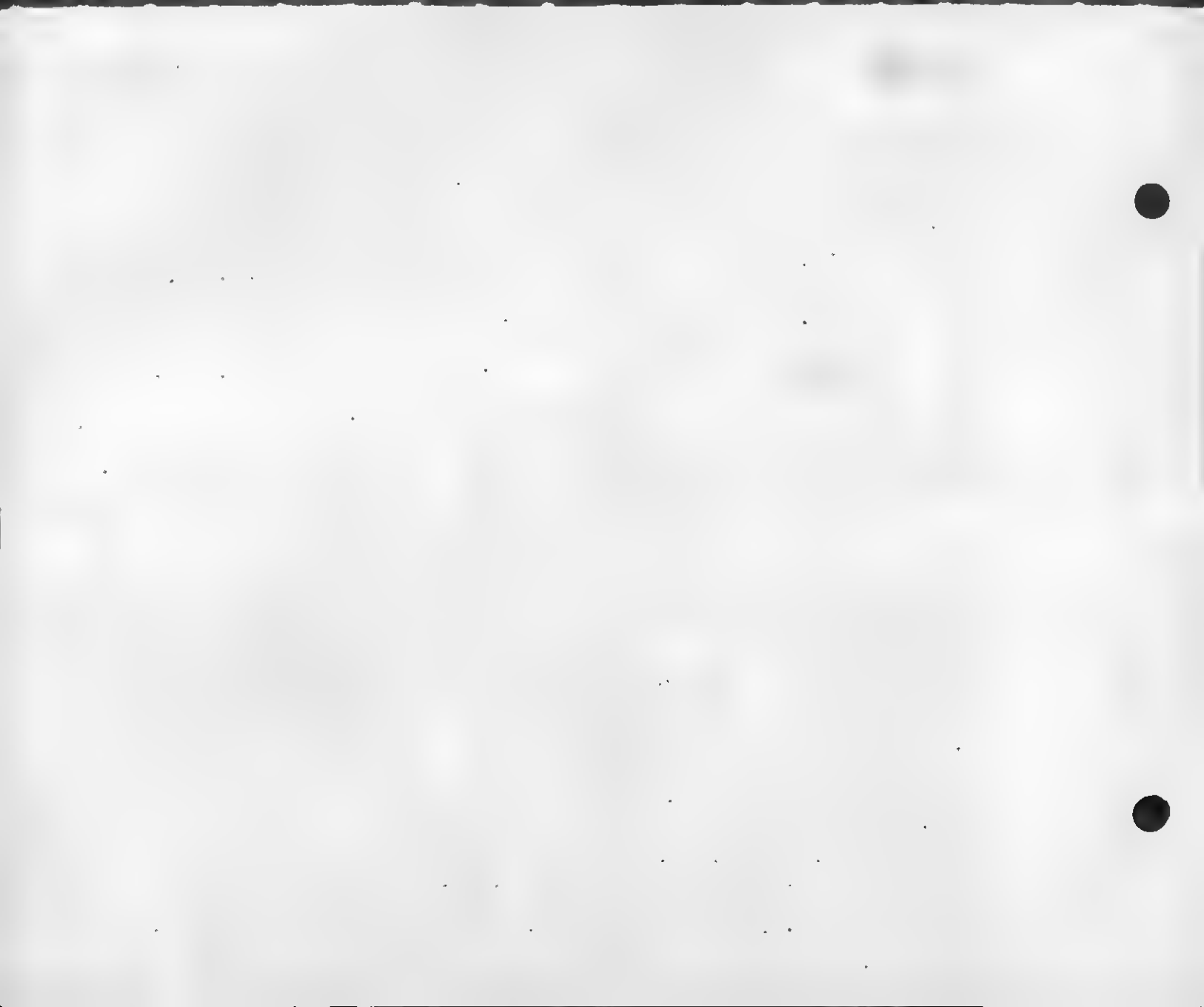
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN ID <u>1 day</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		d. STREET ADDRESS <u>Lewis Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lee Roy Bosley</u>		4. DATE OF DEATH <u>Sept. 10, 1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/90</u>		9. AGE (in years last birthday) <u>76 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery County, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas Bosley</u>		14. MOTHER'S MAIDEN NAME <u>George Washington Bosley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-09-1001</u>		17. INFORMANT <u>Mrs. Shirley Melvin, Damascus, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO (b) <u>Gunshot wound of head</u> DUE TO (c) <u>Self inflicted</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Shot self in head above and in front of right ear with revolver. Bullet lodged left sup. occ. region.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1:50</u> p.m. <u>9/10</u> 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Damascus, Mont., Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>September 10, 1966</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>Sept. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Christian</u>		23d. LOCATION (City, town or county) (State) <u>Hyattstown, Md.</u>		24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>	
25d. ADDRESS (Street, city, town, or county) <u>1919 Seminary Rd, Silver Spring, Md.</u>		25e. ADDRESS (Street, city, town, or county) <u>[Address]</u>		25f. ADDRESS (Street, city, town, or county) <u>[Address]</u>		25g. ADDRESS (Street, city, town, or county) <u>[Address]</u>		25h. ADDRESS (Street, city, town, or county) <u>[Address]</u>		25i. ADDRESS (Street, city, town, or county) <u>[Address]</u>		25j. ADDRESS (Street, city, town, or county) <u>[Address]</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>Hours</u>		d. STREET ADDRESS <u>505 Chillum Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Clarence</u> Last <u>Bowers</u>		4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>	
11. BIRTHPLACE (State or foreign country) <u>Beaver Falls, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Schramm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>193-05-9225</u>	
17. INFORMANT <u>Mrs. Dorothy Bell</u>		Address <u>505 Chillum Road W. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anoxia due to</u> DUE TO (b) <u>anoxia due to</u> DUE TO (c) <u>aspiration of gastric contents</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE CAUSE OF DEATH 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased vomited and aspirated gastric contents</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden Reap</u>		22. DATE SIGNED <u>9-21-1966</u>	
EXAMINER'S NAME (Type) <u>Belden Reap</u>		23. NAME OF CITY OR CEMETERY <u>Fort Lincoln Cemetery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 21, 1966</u>	
23c. NAME OF CITY OR CEMETERY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, Town or county) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
24b. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL ☐ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ☐ be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 ☐ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12866

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lineaton Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lida L. Bradford</u>		4. DATE OF DEATH <u>September 14</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>James Leyshon</u>		14. MOTHER'S MAIDEN NAME <u>Susan Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-2930-Webster C. Leyshon</u>	
17. INFORMANT <u>None</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>		DUE TO (b) <u>Kidney Failure</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)		20f. City or town County, State,	
21. I certify that (I) (this hospital) attended the deceased from <u>8-1-1963</u> to <u>Sept 14, 1966</u> that (I) <u>(was)</u> last saw the deceased alive on <u>Sept 10</u> 19 <u>66</u> , and that death occurred at <u>9:15</u> M from the causes and on the date stated above			
22a. SIGNATURE <u>Edward J. Richards</u>		22b. DATE SIGNED <u>September 14, 1966</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Edward J. Richards</u>		22d. ADDRESS <u>10110 Ya. Avenue, Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>Sept. 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Colesville, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14311

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> COUNTY <u>DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Perey</u> Middle <u>Cecil</u> Last <u>Brady</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Henry Brady</u>		14. MOTHER'S MAIDEN NAME <u>Mary Amanda Brady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>John Brady Silver Spring Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7:55 P 9-29, 1966</u> , to <u>1:45 A 9-30, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-30</u> 19 <u>66</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Eig</u>		22b. DATE SIGNED <u>9-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Blaine H. Eig</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REG. STRAR 25b. REGISTRAR'S SIGNATURE	
		DATE <u>10-1-66</u>	

CERTIFICATE OF DEATH

1256

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a STATE <u>MARYLAND</u> b CO. NTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonville</u>	
c LENGTH OF STAY IN 1b <u>4 days</u>		d STREET ADDRESS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Boy</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1966</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 18, 66</u>
9 AGE (In years last birthday) yrs <u>4</u>		10 F UNDER 1 YEAR Months <u>4</u> Days <u>19</u> IF UNDER 24 HRS Hours <u>19</u> Min <u>66</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b KIND OF BUSINESS OR INDUSTRY	
12 BIRTHPLACE (County & State or foreign country) <u>BETHESDA, MD</u>		13 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME <u>SHERIA BRIGHT</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO	
18 INFORMANT <u>Matthew</u>		Address <u>Ames...</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (th s hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above			
22a SIGNATURE <u>J. Thornton Boswell M.D.</u>		22b DATE SIGNED <u>9.25.66</u>	
22c PHYSICIAN'S NAME (Type) <u>J. Thornton Boswell M.D.</u>		22d ADDRESS <u>Suburban H. & A. 1000 N. 1st St. Laytonville</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>9/26/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Brooke Grove Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Laytonville, Md.</u>
24 F. M. DIRECTOR <u>L. Snowden</u>		25a REC'D BY REGISTRAR <u>St</u> DATE <u>9/25/66</u>	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12874

12868

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY (If 1b) <u>13 days</u>	
d NAME OF HOSPITAL, OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		e STREET ADDRESS <u>5010 Newport Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>GEORGE A.</u> Middle <u>B.</u> Last <u>BROWN</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1966</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 3, 1907</u>
9 AGE (In years last birthday) <u>58</u> yrs		10 IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u> Hours <u>14</u> Min <u></u>	
11a USUAL OCCUPATION (Give kind of work done during most of work, if retired) <u>Housewife</u>		11b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (Country & State or foreign country) <u>West Virginia</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>William Harrison Brown</u>		14 MOTHER'S MAIDEN NAME <u>Ann Jane Glenn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>236-14-4566</u>	
17 INFORMANT <u>Daughter</u>		Address <u>Same as Item 2.</u>	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4 - - - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>senile heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (th s hospital) attended the deceased from <u>Jan</u> , 19 <u>63</u> to <u>Sept</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> , 19 <u>66</u> , and that death occurred at <u>7 P</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Marvin Wadler</u>		22b DATE SIGNED <u>9/20/66</u>	
22c PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d ADDRESS <u>8218 Wood Ave, Beth, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-22-66</u>		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY <u>Bluemont Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Grafton, West Virginia</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a REC'D BY REGISTRAR <u>SEP 22 1966</u>		25b REGISTRAR'S SIGNATURE <u>Jorge</u>	

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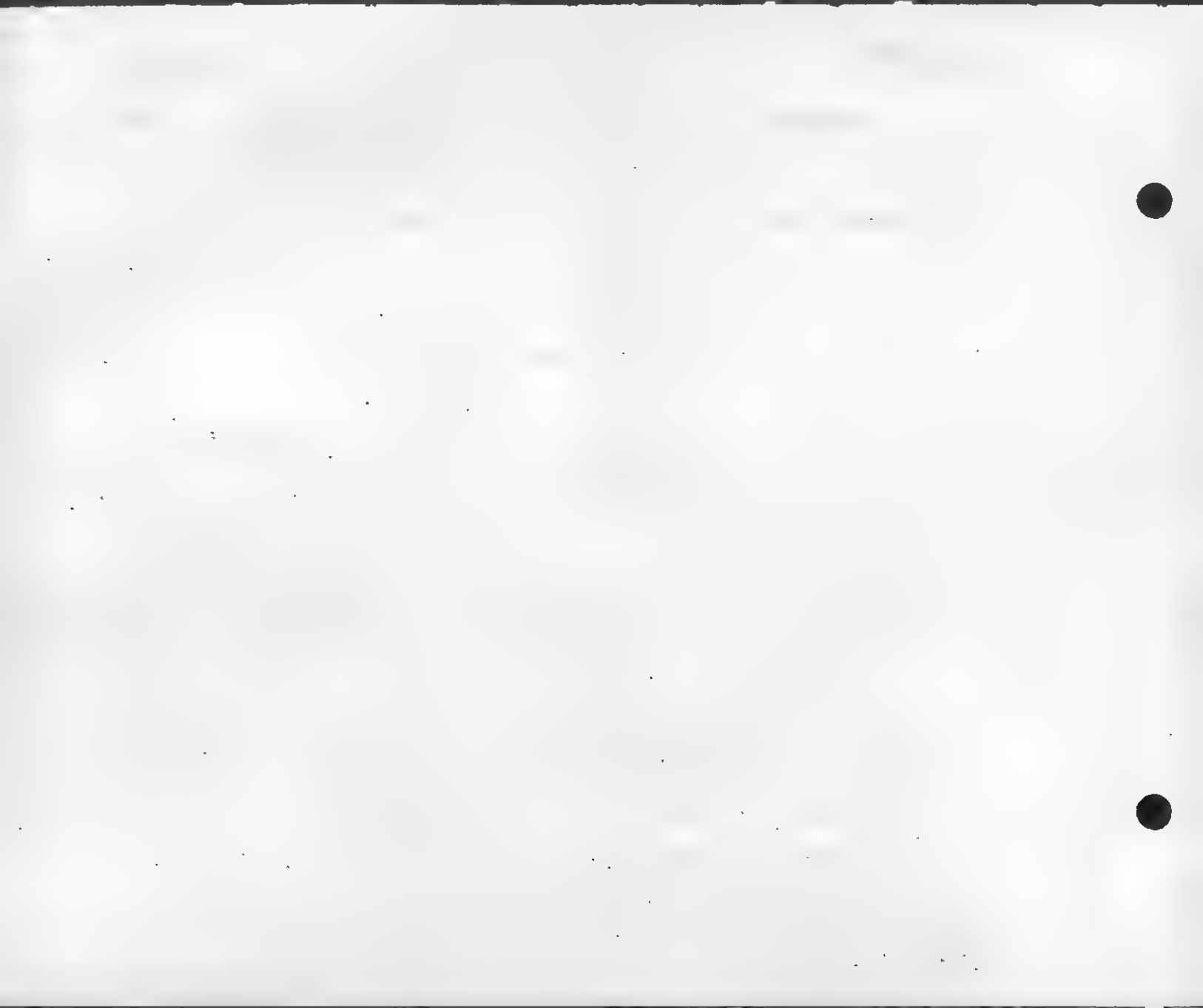


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12869

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
c. LENGTH OF STAY IN 1b <u>6 years</u>			d. STREET ADDRESS <u>4005 Beverly Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4005 Beverly Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Willse</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1908</u>	9. AGE (In years last birthday) <u>58 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Maryland</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Westfield, N. Y.</u>	
13. FATHER'S NAME <u>Hudson R. Willse</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>217-32-0909</u>		
17. INFORMANT <u>C. Willman Brown</u>			Address <u>4005 Beverly Road Rockville, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH. <u>7 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20, 1966</u> to <u>Sept. 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 30, 1966</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Frederick Mooman</u> M.D.				22b. DATE SIGNED <u>Sept. 30, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick Mooman, M.D.</u>				22d. ADDRESS <u>4000 Beverly Rd., Rockville, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Norfolk, Virginia</u>					
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>NOT</u> <u>5 13 66</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

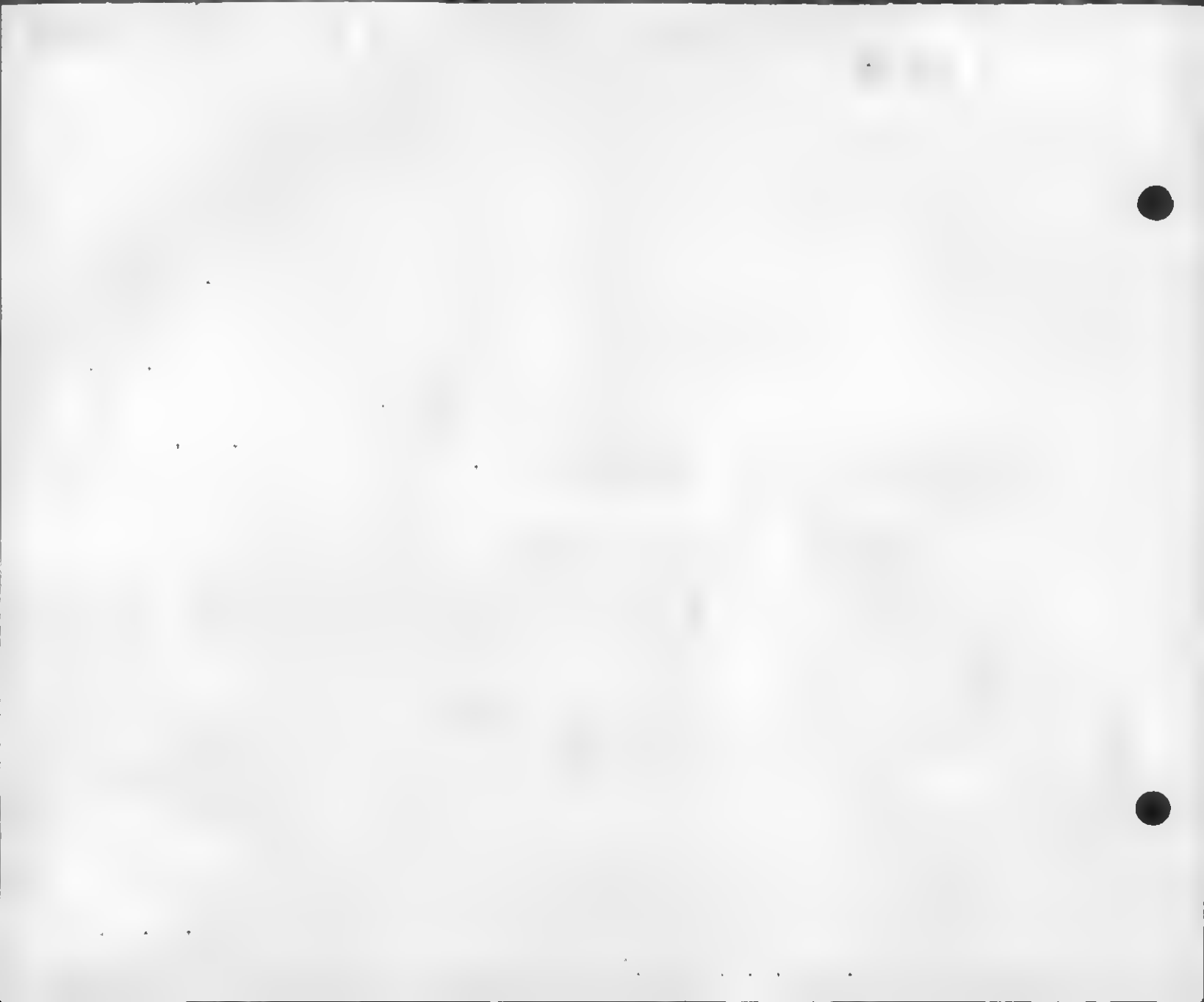
12870

CERTIFICATE OF DEATH

Classed as Coronary

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Kenwood c LENGTH OF STAY IN 1b Kenwood		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6412 Highland Drive		d STREET ADDRESS 6412 Highland Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Marshall Earl Brushhart		4 DATE OF DEATH Month Day Year Sept. 11, 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-24-1896
9 AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a U.S.A. OCCUPATION Give kind of work done (If not working give title, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Michigan		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Brushhart		14. MOTHER'S MAIDEN NAME Josephine Morris	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918		16 SOCIAL SECURITY NO 579-52-4399	
17 INFORMANT Mrs. Ruthanna Maxwell Brushhart		Address 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO (b) Massive Coronary Occlusion DUE TO (c) _____ Conditions (only which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH instant	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 Previous coronary thromboses -		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 8-11 , 19 66 , that (I) (we) last saw the deceased alive on 7-3 , 19 66 , and that death occurred at 4:30 PM, from causes and on the date stated above.			
22a. SIGNATURE Geo. R. Huffman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) GEORGE R. HUFFMAN		22d. ADDRESS 1912 - R St. Wash. D.C.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-14-1966	23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d LOCATION (City or Town) (County) (State) Washington D.C.
24 FUNERAL DIRECTOR Joseph Lawler's Sons, Inc.		25a. REC'D BY REGISTRAR SEP 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

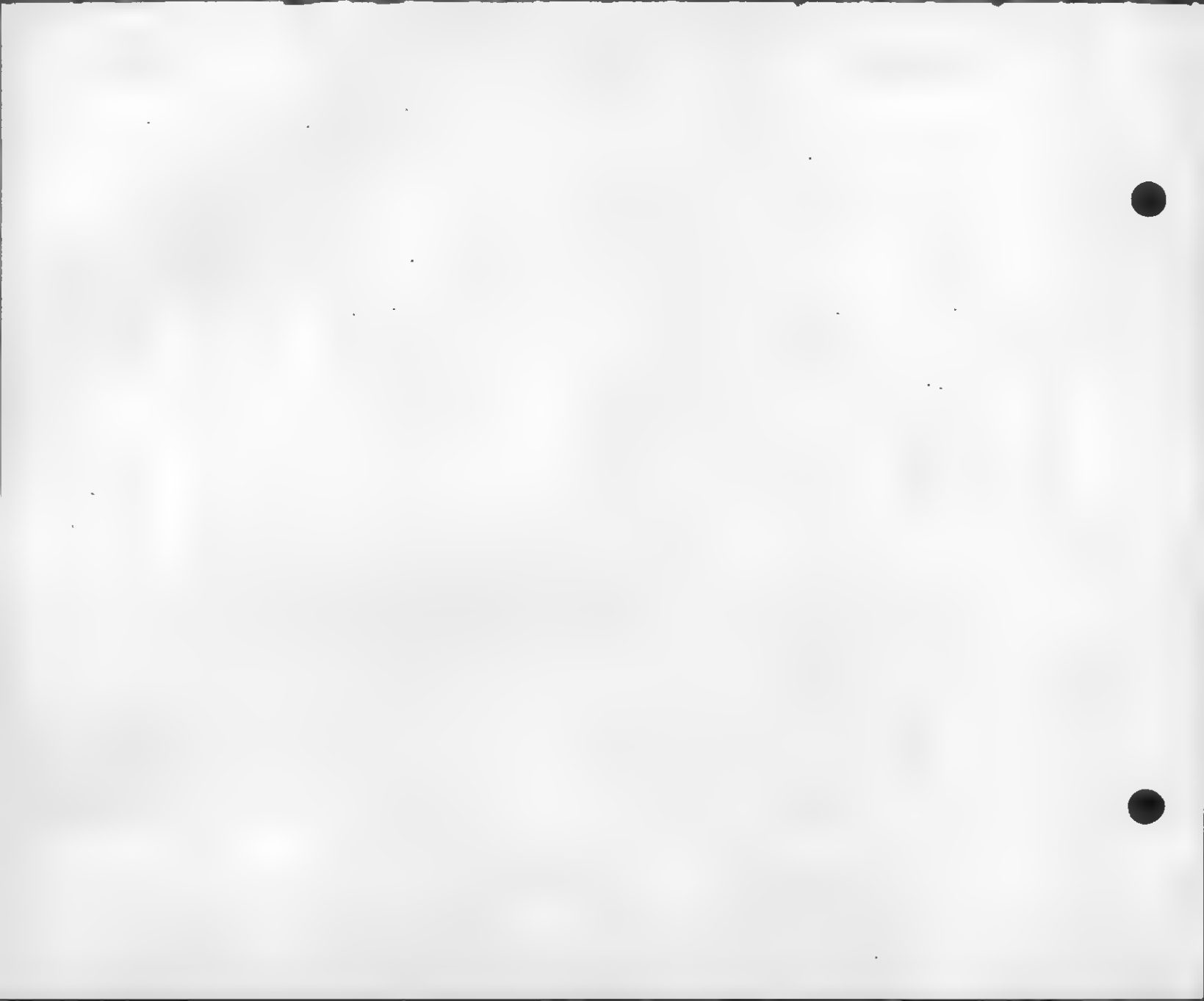
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12877
CERTIFICATE OF DEATH
12871

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2616 Kensington Blvd.</u>		d. STREET ADDRESS <u>2616 Kensington Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>ETTA</u> Last <u>BURGESS</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 7, 1877</u>
9. AGE (in years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Cato Poole</u>		14. MOTHER'S MAIDEN NAME <u>Tamar Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-50 6396</u>	
17. INFORMANT <u>Mrs. Mary Murphy</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>STROKE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <u>HYPERTENSION, HEART DISEASE</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER FACE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 6</u> , 19 <u>57</u> , to <u>SEPT 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 16</u> , 19 <u>66</u> , and that death occurred at <u>2754</u> M, from the causes and on the date stated above.			22b. DATE SIGNED
22a. SIGNATURE <u>Robert L. Snowden</u>		22c. PHYSICIAN'S NAME (Type) <u> </u>	
22d. ADDRESS <u> </u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>	23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>SEP 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>so Judge</u>		25c. DATE <u>SEP 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

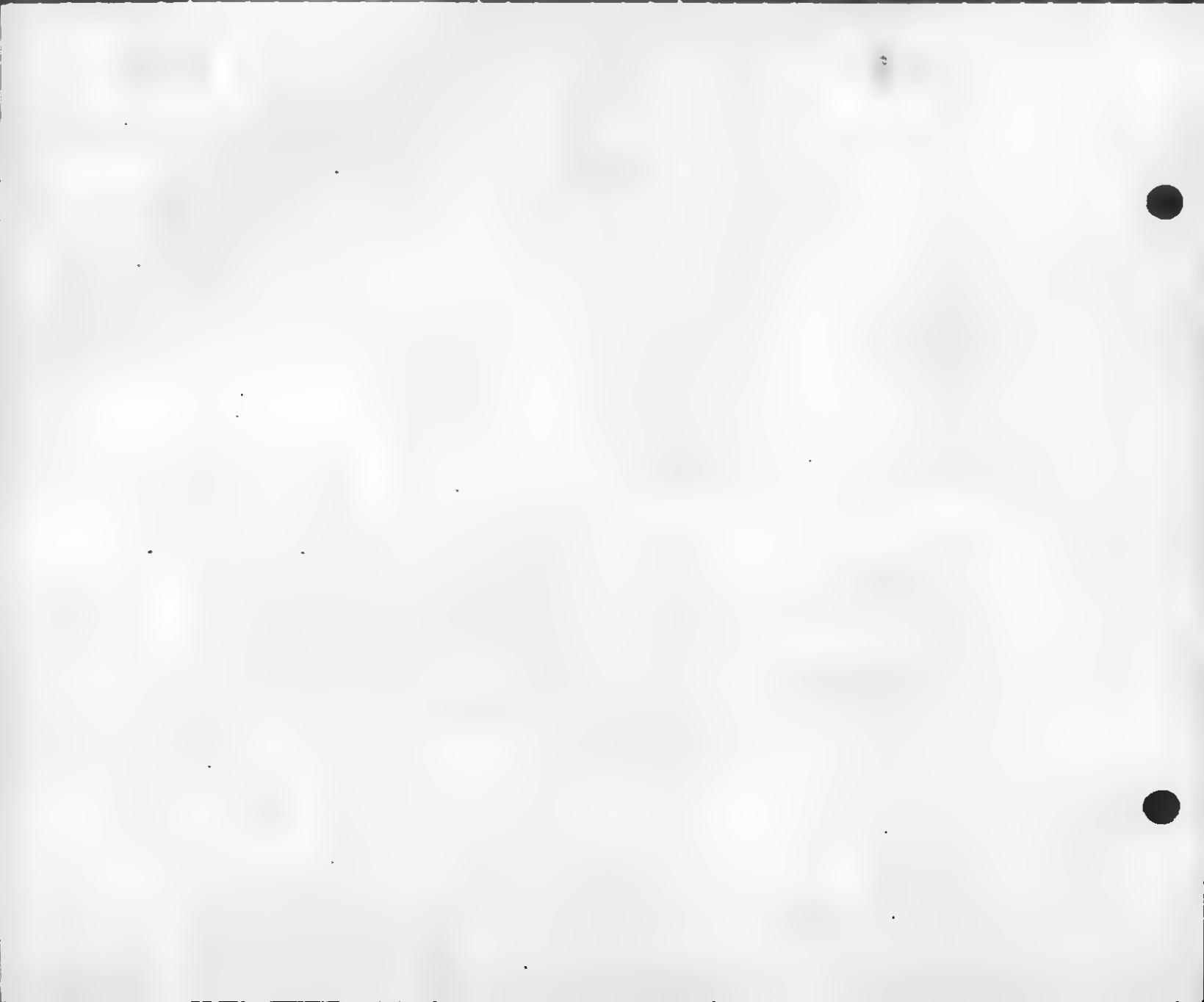
CERTIFICATE OF DEATH

12872

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission, b STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN <u>8 days</u>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>10820 Georgia Ave</u>	
3 NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>A</u> Last <u>Burton</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/9/1896</u>
9 AGE (In years last birthday) <u>69</u> yrs		10 IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> IF UNDER 24 HRS Months <u>9</u> Days <u>9</u> Mins <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Police</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Police</u>	
11 BIRTHPLACE (Country & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>U. S. T. Burton</u>		14 MOTHER'S MAIDEN NAME <u>Edna Wittmer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. (If yes give war or dates of service)) <u>No</u>		16 SOCIAL SECURITY NO. <u>578-44-030</u>	
17 INFORMANT <u>Edna Wittmer</u>		Address <u>14.5 E. ...</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive cardiac vascular disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-17-1960</u> , 19 <u>60</u> , to <u>2-18-1966</u> , that (I) (we) last saw the deceased alive on <u>7-18-1966</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above			
22a SIGNATURE <u>John S. ...</u> M.D.		22b DATE SIGNED <u>9/18/66</u>	
22c PHYSICIAN'S NAME (Type) <u>John S. ...</u>		22d ADDRESS <u>5525 ...</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>9/21/1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		23d LOCATION (City or Town) (County) (State) <u>ARLINGTON, VIRGINIA</u>	
24 FUNERAL DIRECTOR <u>PHYSICIAN'S HOME</u>		25a REC'D BY REGISTRAR <u>SEP 20 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12873

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN Takoma Park c LENGTH OF STAY IN TB Washington D.C.		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE MARYLAND b COUNTY Washington D.C.	
3 NAME OF DECEASED (Type or print) Albert Henry RUSCHLING		4 DATE OF DEATH Month 9 Day 13 Year 1966	
5 SEX m	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 9-2-94
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Pressman		9b KIND OF BUSINESS OR INDUSTRY Illinois	10 AGE (in years last birthday) 72 YRS
11 BIRTHPLACE (County & State, or foreign country) Illinois		12 CITIZEN OF WHAT COUNTRY? Amer.	
13 FATHER'S NAME William		14 MOTHER'S MAIDEN NAME Jo Anna	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Patient's Chart.	
17 INFORMANT Patient's Chart.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18)	
20c TIME OF DEATH (Month, Day, Year) Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1-8 , 19 66 , to Sept. 13 , 19 66 that (I) (we) last saw the deceased alive on Sept 13 , 19 66 , and that death occurred at 5:30 p.m. from causes and on the date stated above.			
22a SIGNATURE E. INC MAGI		22b. DATE SIGNED Sept. 13, 1966	
22c. PHYSICIAN'S NAME (Type) E. INC MAGI		22d. ADDRESS 851 Univ Blvd. E., Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF Sept. 16, 1966	23c NAME OF CEMETERY OR CREMATORY Diocese Washington	23d LOCATION (City or Town) (County) (State) Adelphi Md.
24 FUNERAL DIRECTOR John J. Kautz		25a. REC'D BY REGISTRAR SE	
25b REGISTRAR'S SIGNATURE John J. Kautz		25c ADDRESS 254 Carroll St. N.W. D.C.	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

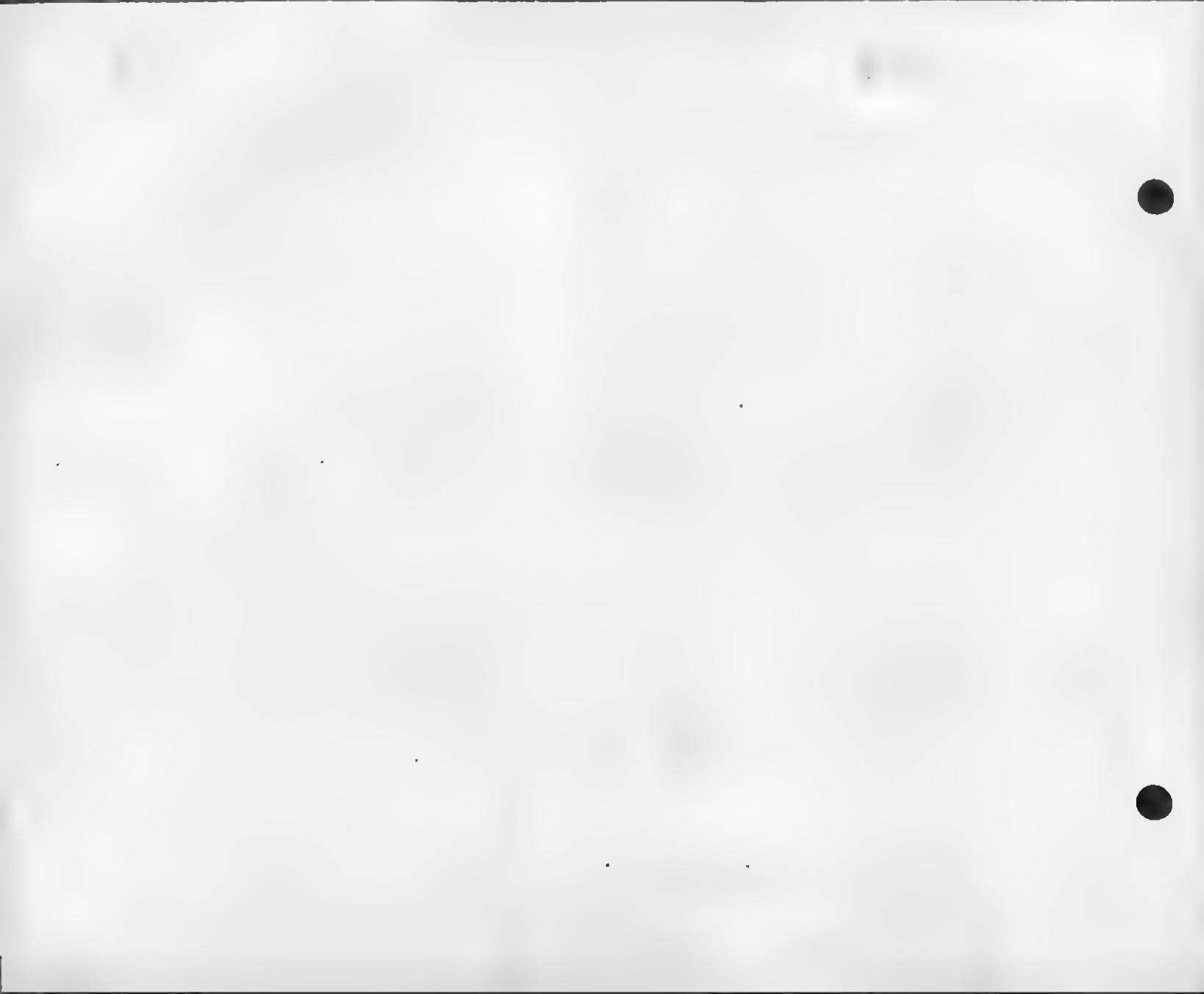
CERTIFICATE OF DEATH

1966

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1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN TB 4 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS 5717 First Street, South	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Patricia Murray CAHILL		4 DATE OF DEATH Month September Day 23 Year 1966	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 17, 1924
9 AGE in years (last birthday) 41 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife	10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (Country & State or foreign country) Bronx, New York		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown Lewis MURRAY		14 MOTHER'S MAIDEN NAME Evelyn Heelan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 100-18-4121	
17 INFORMANT CDR John CAHILL Address 5717 First Street, South, Arlington, Va.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Left Breast with widespread Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that Patricia (this hospital) attended the deceased from 19 Sept. , 1966, to 23 Sept. , 1966, that she (we) last saw the deceased alive on 23 Sept. 1966, and that death occurred at 2:20 PM , from causes and on the date stated above			
22a SIGNATURE Stanley S. WEGLARZ M.D.		22b DATE SIGNED 24 Sept 1966	
22c PHYSICIAN'S NAME (Type) Stanley S. WEGLARZ M.D.		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-27-66	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Murphy Funeral Home ADDRESS 3524 Columbia Pike, Arlington, Va		25a REQ. BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE



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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12875

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Bethesda		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE Florida b. COUNTY Lee c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bokeelia	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Naval Hospital, Bethesda, Maryland		d STREET ADDRESS Box 44 e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Ford Alberto CAMPBELL		4 DATE OF DEATH Month Day Year Sept 1 1966	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 JULY 1910 9 AGE in years (last birthday) 56
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b KIND OF BUSINESS OR INDUSTRY N/A	11 BIRTHPLACE (County & State or foreign country) Washington, D.C. 12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Robert Campbell		14 MOTHER'S MAIDEN NAME Parmelia Smith	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO 578-22-8492	17 INFORMANT Mrs. Ruth A. Campbell 324 Independence Ave Washington, D.C.
B CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse hemorrhage right lung DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma (Epidermoid) DUE TO (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) NA	
20c TIME OF INJURY Month, Day Year Hour a.m. NA p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> NA <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NA	20f. (City or town) (County) (State) NA
21 I certify that XX (this hospital) attended the deceased from 1 August, 1966 to 1 Sept., 1966 that (X) (we) last saw the deceased alive on 1 September 1966 , and that death occurred at 12:30 PM from causes and on the date stated above.			
22a SIGNATURE Robert J. Kinney		22b. DATE SIGNED 3 September 1966	
22c PHYSICIAN'S NAME (Type) Robert J. Kinney LCDR MC USN		22d ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a BURIAL, CREMATION, or other disposition (Specify) Burial	23b DATE THEREOF 9-6-1966	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Va.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Mattingly Funeral Home		25a REC'D BY REGISTRAR DATE SEP 6 1966	25b REGISTRAR'S SIGNATURE [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12882

12876

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>12 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Suburban Ind Hospital</i>		d. STREET ADDRESS <i>7500 Maple Avenue</i>	
3 NAME OF DECEASED (Type or print) <i>Ray Glenn Campbell</i>		4 DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1966</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF BIRTH <i>4-9-03</i>
10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired <i>Minister</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Soc. Sec. Administration</i>	
11 BIRTHPLACE (County & State or foreign country) <i>Michigan</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>Alexander Campbell</i>		14 MOTHER'S MAIDEN NAME <i>Chloe Everts</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>no</i>		16 SOCIAL SECURITY NO. <i>no</i>	
17 INFORMANT <i>Washington Sub. Hospital Records</i>		Address <i>Takoma Park Md</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute upper GI Hemorrhage</i> DUE TO (b) <i>massive myocardial infarction</i> DUE TO (c) <i>Diabetic Mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8 dys</i> <i>several yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hypertension, obesity</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (1) (the hospital) attended the deceased from <i>Jan</i> , 1965, to <i>9-13</i> , 1966, that (1) (we) lost the deceased alive on <i>9-13</i> , 1966, and that death occurred at <i>7:30</i> P.M. from causes and on the date stated above			
22a. SIGNATURE <i>R.H. Sandstrom</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R.H. Sandstrom MD</i>		22d. ADDRESS <i>770. Carroll Ave Takoma Park, Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <i>Sept 17-1966</i>	23c NAME OF CEMETERY OR CREMATORY <i>H. Lincoln</i>	23d LOCATION (City or town) (County) (State) <i>Frederickville, Md</i>
24 FUNERAL DIRECTOR <i>Frederickville 29 Washington, D.C.</i>		25a RECD BY REGISTRAR <i>SEP 12 1966</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1257

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN "b" 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		e. STREET ADDRESS Rt. 1, Box 389	
3 NAME OF DECEASED (Type or print) First Rachel Middle Elizabeth Last Carroll		4. DATE OF DEATH Month 9 Day 29 Year 1966	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-28-1883
9 AGE (in years last birthday) 83 yrs		10 IF UNDER 1 YEAR Months 10 Days 29 Hours 10 Mins 10	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) charwoman		12 KIND OF BUSINESS OR INDUSTRY U.S. Government	
13 BIRTHPLACE (Country & State or foreign country) Maryland		14 CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
15 FATHER'S NAME Wesley Boyd		16 MOTHER'S MAIDEN NAME Johnson	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18 SOCIAL SECURITY NO no	
19 INFORMANT Hospital admission record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Congestive Heart Failure DUE TO Lobar Pneumonia DUE TO Hypertensive C.V. Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days 7 hrs	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th s hospital) attended the deceased from 9/29/66 , 1966, that (I) (we) last saw the deceased alive on 9/29 , 1966, and that death occurred at 2:10 p.m. , from causes and on the date stated above		22a. SIGNATURE Jack Schmecher, M.D.	
22b. PHYSICIAN'S NAME (Type) Jack Schmecher, M.D.		22c. ADDRESS Gaithersburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/3/66	
23c. NAME OF CEMETERY OR CREMATORY Brooke Grove		23d. LOCATION (City or Town) (County) (State) Gaytonsville Md.	
24. FUNERAL DIRECTOR Robert L. Sporden Rockville, Md.		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2884

12878

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Chillum</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanand Hospital</u>			d. STREET ADDRESS <u>6500 8th Ave</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Antonic</u> Middle <u>MM</u> Last <u>CATERA</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. CO. OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-01</u>	9. AGE (In years last birthday) <u>65</u> yrs	FUNERAL YEAR Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min <u>66</u>
10a. OCCUPATION (Give kind of work done during last 12 months) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>	11. BIRTHPLACE (Country & State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Giuseppe CATERA</u>			14. MOTHER'S MAIDEN NAME <u>Rosa BRIENZA</u>		
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>579-01-9409</u>	17. INFORMANT <u>Hospital Records</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Diabetes mellitus</u> DUE TO (b) <u>2 days</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1966</u> to <u>Sept 18, 1966</u> , that (we) last saw the deceased alive on <u>Sept 17, 1966</u> , and that death occurred at <u>3:45 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>E. P. Ingel</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/18/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>E P INGEL</u>		22d. ADDRESS <u>1222 MONROE ST NE WASH DC</u>			
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>9-22-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>	23d. LOCATION (City or Town) <u>BLADENBURG MD</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS & CO. RIVERDALE MD</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

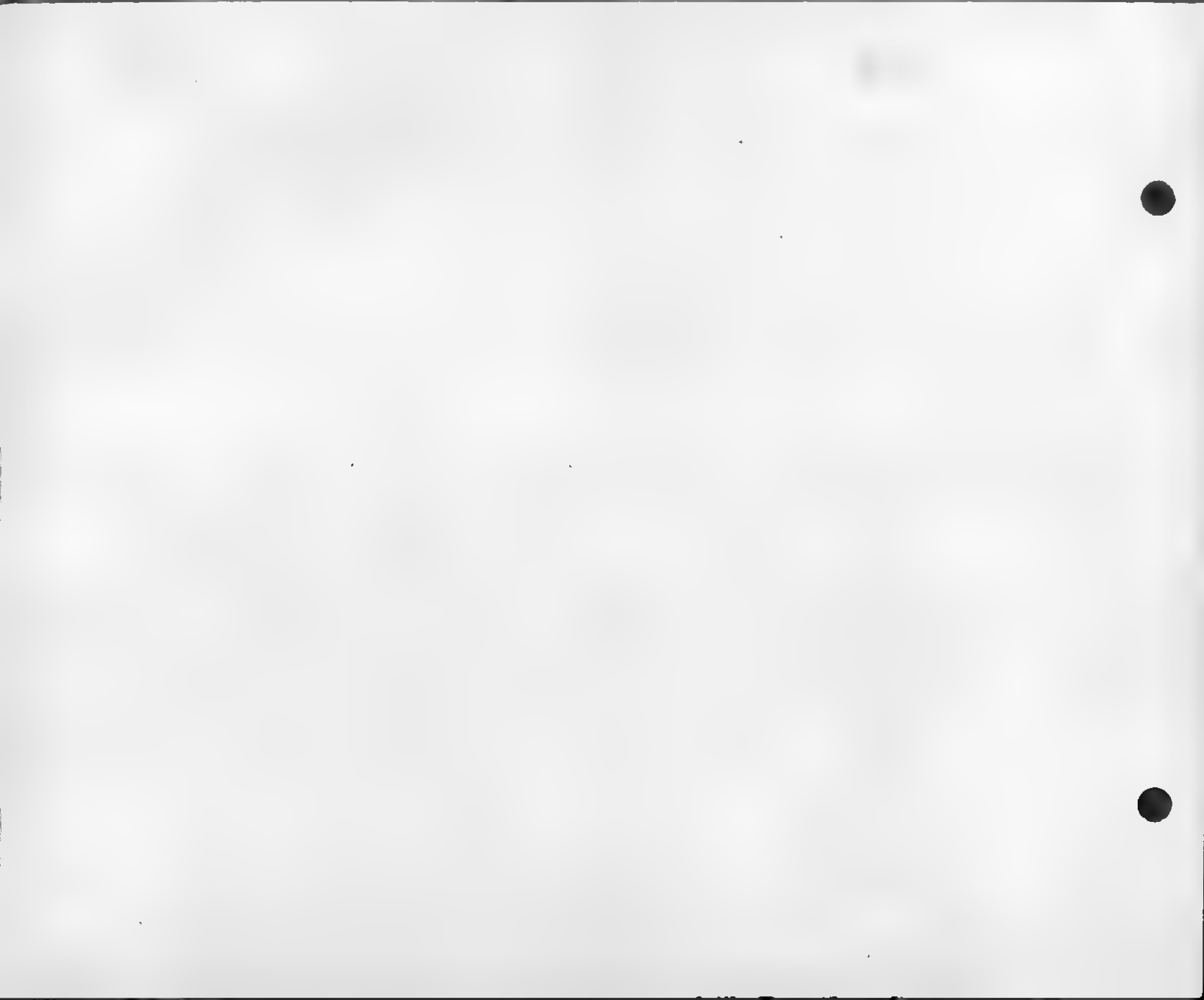
CERTIFICATE OF DEATH

12579

1 PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE <i>Maryland</i>	
c. CITY OR TOWN (If outside corporate limits, write R.J.R. and give nearest town) <i>Prince Georges</i>		d. LENGTH OF STAY IN Ia <i>4-2-66</i>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington General Hospital</i>		f. STREET ADDRESS <i>2119-11th St. N.W.</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>HELEN (N.M.) CHARLES</i>		4 DATE OF DEATH Month Day Year <i>September 1 1966</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>1-1-24</i>
9 AGE (In years last birthday) <i>42 yrs.</i>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11 BIRTHPLACE (County & State or foreign country) <i>Greece</i>	
12 CITIZEN OF WHAT COUNTRY? <i>!! - A</i>		13 FATHER'S NAME <i>Panayioti Manolakis</i>	
14 MOTHER'S MAIDEN NAME <i>Panayiota</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	
16 SOCIAL SECURITY NO. <i>579-44-4991</i>		17 INFORMANT Address <i>Mrs. Pauline Anthos 4406 Old Capitol Trail Delmar, Delaware</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>HEART ATTACK OF FIBRILLATION</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. _____ 1966	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>Sept 1</i> , 1966 to <i>Sept 1</i> , 1966 that (I) (we) last saw the deceased alive on <i>1 Sept 1966</i> and that death occurred at <i>10:45</i> M, from causes and on the date stated above.			
22a SIGNATURE <i>Walter G. Goch</i>		22b DATE SIGNED <i>1 Sept 66</i>	
22c PHYSICIAN'S NAME (Type) <i>WALTER GOCH MD</i>		22d ADDRESS <i>2341 GLENNVIEW CIR</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <i>Sep. 6, 1966</i>	23c NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>
24 FUNERAL DIRECTOR <i>Clark E. Visor Warner E. Humphrey, Inc.</i>		25a REC'D BY REGISTRAR <i>SEP 7 1966</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

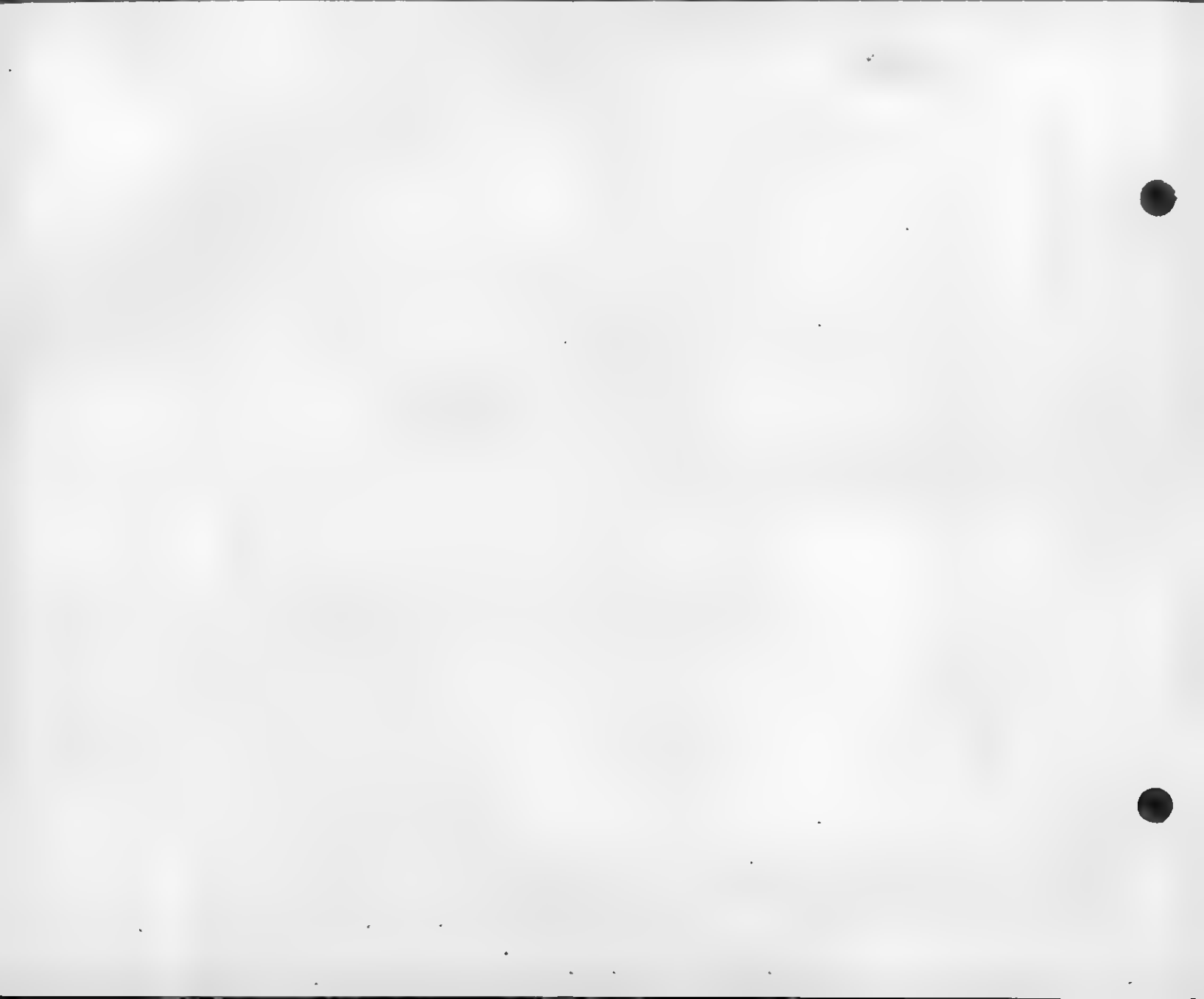
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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>1 1/2</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Elizabeth's Hospital</u>		d STREET ADDRESS <u>10620 Georgia Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOHN HOGAN CLAIBORNE</u>		4 DATE OF DEATH Month Day Year <u>9 20 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Month Day Year <u>1 1 1911</u>
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>JOHN HOGAN CLAIBORNE</u>		14 MOTHER'S MAIDEN NAME <u>SUSAN BELLE ONEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWI</u>		16 SOC. A. SECURITY NO. <u>- - -</u>	
17 INFORMANT <u>LILLIAN N. CLAIBORNE -</u> Address <u>See Item #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Brain Tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Osteoporosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1965</u> to <u>Sept 20, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 20, 1966</u> and that death occurred at <u>4:05 PM</u> from causes and on the date stated above.			
22a SIGNATURE <u>John J. Curry</u>		22b DATE SIGNED <u>9/20/66</u>	
22c PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d ADDRESS <u>10620 Georgia Avenue</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9-22-1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d LOCATION (City or town) (County) (State) <u>Arlington Md</u>
24 FUNERAL DIRECTOR <u>Joseph Taylor's Sons, Inc.</u>		25a REC'D BY REGISTRAR DATE <u>SEP</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>



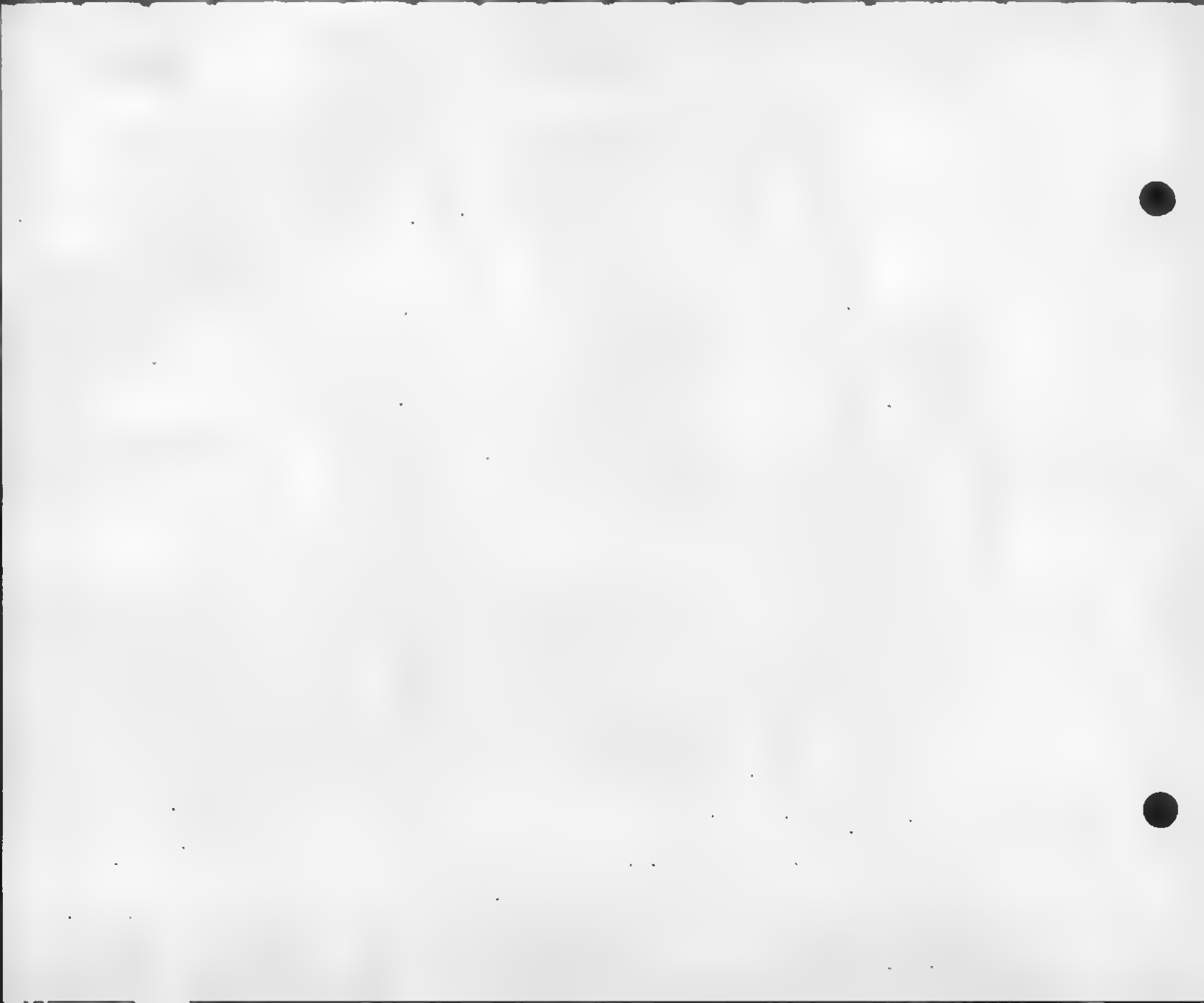
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>55 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>606 Sligo Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>606 Sligo Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John A. Clark</u> First Middle Last 4. DATE OF DEATH <u>September 2</u> 19 <u>66</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 22, 1886</u> 9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u> 13. FATHER'S NAME <u>Bailey R. Clark</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> 14. MOTHER'S MAIDEN NAME <u>Emma Hardesty</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs. Grace Clark</u> Address <u>606 Sligo Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1950</u> , to <u>Sept 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 1966</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>W. B. Wardrop, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop, M.D.</u>		22b. DATE SIGNED <u>Sept 2, 1966</u> 22d. ADDRESS <u>800 Pershing Drive, S. S., Md.</u>		22e. REC'D BY REGISTRAR <u> </u> 25d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City, Town or county) <u>Prince Georges Co., Md.</u>		23e. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>		e STREET ADDRESS <u>9904 PORTLAND RD.</u>	
3 NAME OF DECEASED (Type or print) First <u>LEOYD</u> Middle <u>MASON</u> Last <u>CLARK</u>		4 DATE OF DEATH Month <u>SEPT.</u> Day <u>17</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-10-92</u>
9 AGE (In years last birthday) <u>74</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Manufacturing</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Metal screens</u>	
11 BIRTHPLACE (County & State or foreign country) <u>IOWA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Seymour Clark</u>		14 MOTHER'S MAIDEN NAME <u>Anna Mae Tarrence</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>217-32-1160</u>	
17 INFORMANT <u>Hossie B. Clark</u>		Address <u>9904 Portland Road Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO (b) <u>Benignignous Carcinoma - metastases</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			19 INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>6 mo's.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis and Emphysema; Hypertensive Cardiovascular Disease</u>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u> </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>Sept 17</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>September 17</u> , 19 <u>66</u> , and that death occurred at <u>9:42</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Harold W. Draper</u> M.D.		22b DATE SIGNED <u>Sept 17, 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER, M.D.</u>		22d ADDRESS <u>10620 GEORGIA AVE, SILVER SPRING, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Sep. 21, 1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24 FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a RECD BY REGISTRAR <u> </u>	
25b REGISTRAR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25c ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

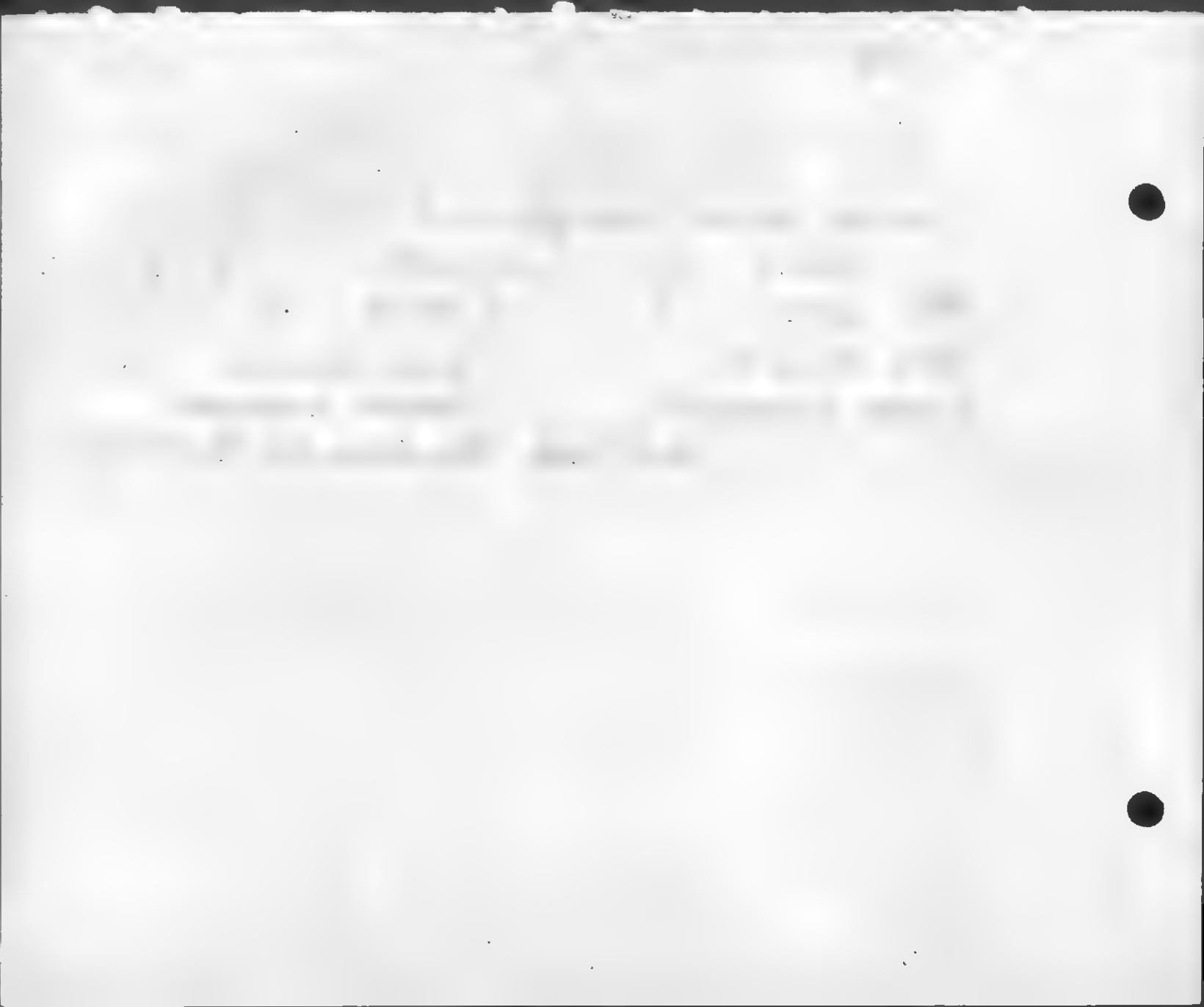
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared through Medical Examiner, Dr. Belton Reap

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12883

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT GOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
c. LENGTH OF STAY IN 1b <u>2 days</u>				d. STREET ADDRESS <u>8314 CAREY LANE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JUDSON W. CLEMENTS</u>				4. DATE OF DEATH <u>9 2 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-83</u>	
9. AGE (in years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSP. PENNA. R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ROME GEORGIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CISERO CLEMENTS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH WARDLAW</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>716 16 7573A</u>		17. INFORMANT <u>ROSE LATVA RN.</u>		Address <u>2101 FAIRLAND RD. SILVER SPRING, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypopharyngeal Carcinoma</u>				(c) <u>6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>Sept.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 31</u> , 19 <u>66</u> , and that death occurred at <u>9^{PM}</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Allen S. Gardner</u>				22b. DATE SIGNED <u>Sept 2, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Allen S. Gardner</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town or county) (State)				23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				ADDRESS <u>254 Canal St. Baltimore</u>		DATE <u>SEP 7 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12884

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
c. LENGTH OF STAY in Id. <u>13 days</u>		d. STREET ADDRESS <u>9606 Falls Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>John</u> First <u>John</u> Middle <u>St</u> Last <u>Cooking</u>		4 DATE OF DEATH <u>Sept 22</u> 19 <u>66</u> Month <u>Sept</u> Day <u>22</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/25/10</u>
9 AGE <u>56</u> years <u>5</u> months <u>4</u> days <u>27</u> hours <u></u> minutes		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Remains</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>TRU</u>		11 BIRTHPLACE (County & State, or foreign country) <u></u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William</u>	
14. MOTHER'S MAIDEN NAME <u></u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>091-20-8096</u>		17. INFORMANT <u>Mrs. Adele C. Coakley-Wife-9606 Falls Rd.</u> Address <u>Potomac, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>terminal Embolization</u> DUE TO <u>221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acute myocardial infarction</u> DUE TO <u>2 weeks</u> (c) <u>coronary heart disease</u> <u>2 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-27</u> , 19 <u>66</u> , to <u>9-22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-24</u> , 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M., from causes and on the date stated above			
22a SIGNATURE <u>William H. Killay, M.D.</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATES SIGNED <u>SEP 22 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>William H. Killay, M.D.</u>		22d ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9/24/1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a RECD BY REGISTRAR <u>SEP 22 1966</u> DATE <u>SEP 22 1966</u>	
25b REGISTRAR'S SIGNATURE <u>J. Charles</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and for any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

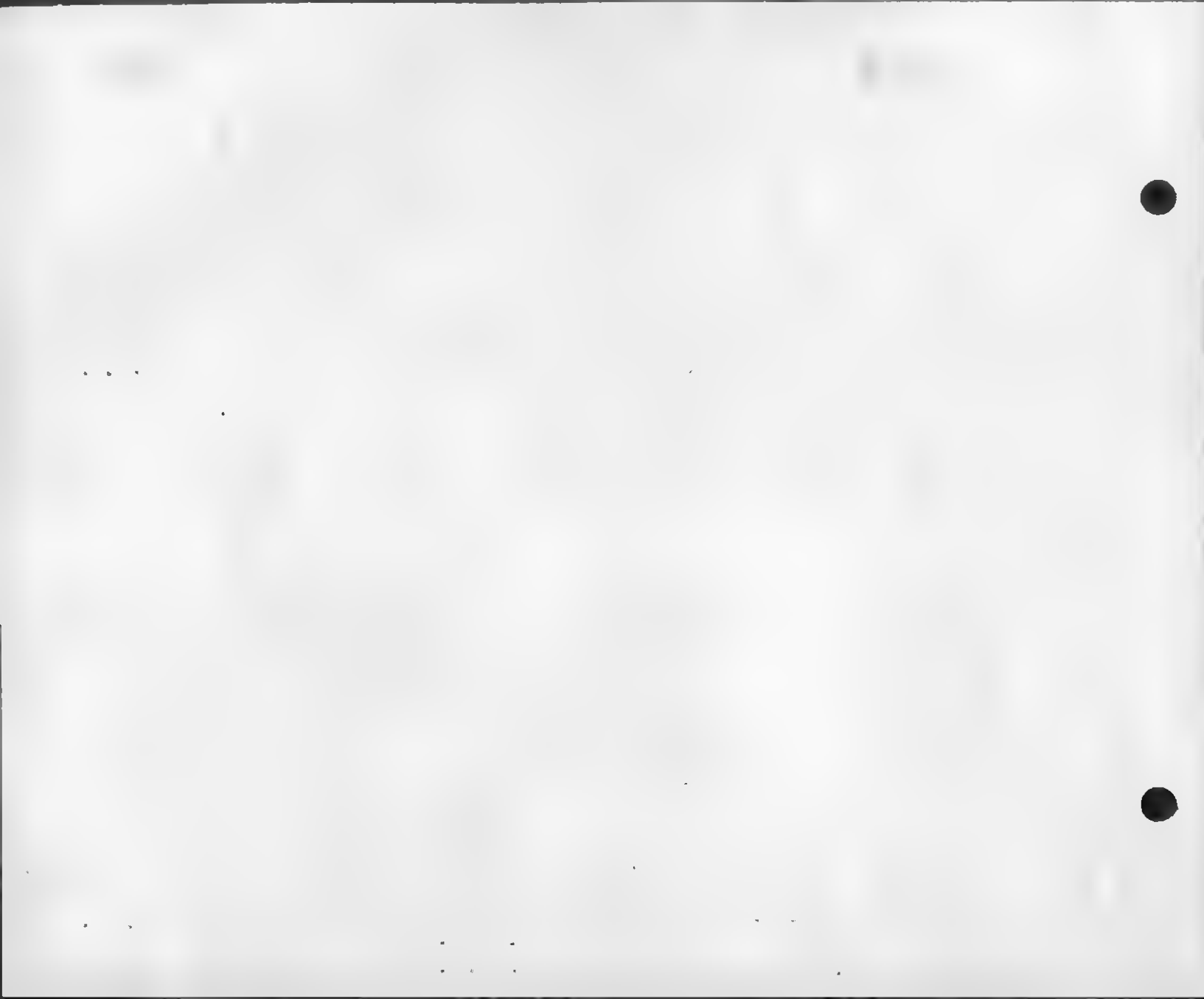
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12885

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>SILVER SPRING</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>14 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>HOLY CROSS HOSPITAL</u>		d STREET ADDRESS <u>3115 S. ...</u>	
3 NAME OF DECEASED (Type or print) <u>MARY</u>		4 DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/7/09</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOV'T.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
13 FATHER'S NAME <u>JOHN MCCARTHY</u>		14 MOTHER'S MAIDEN NAME <u>BRIDGET T. REED</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>MISS THERESA COLLINS SAME AS # 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with Metastases</u> DUE TO <u>1955</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>lost</u> (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>Sept 26</u> , 19 <u>66</u> ; that (I) <u>was</u> last saw the deceased alive on <u>Sept 25</u> , 19 <u>66</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>William D. Aud</u> M.D.		22b DATE SIGNED <u>9/26/66</u>	
22c PHYSICIAN'S NAME (Type) <u>William D. Aud, M.D.</u>		22d ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9-29-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24 FUNERAL DIRECTOR <u>Francis J. Collins</u>		25a REC'D BY REG STRAR <u>Francis J. Collins</u>	
25b REG STRAR'S SIGNATURE <u>Francis J. Collins</u>		DATE <u>9/26/66</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12886

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE _____ b COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 41 days	
c CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Washington, D.C.		d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital	
e STREET ADDRESS 4925 E. Capitol St.		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph A. Connor		4 DATE OF DEATH Month Day Year September 18, 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/18/10
9 AGE (in years last birthday) 56 yrs		10 UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10b KIND OF BUSINESS OR INDUSTRY Virginia	
11 BIRTHPLACE (County & State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Peter J. Connor		14 MOTHER'S MAIDEN NAME Bridgett	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Hospital records		Address _____	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Carcinoma, Right Kidney DUE TO (c) _____			
19 INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/8/66</u> , 19 <u>66</u> , to <u>9/17/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/17/66</u> , 19 <u>66</u> , and that death occurred at <u>8:30 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Timothy James Tehan M.D.</i>		22b. DATE SIGNED 9/19/66	
22c. PHYSICIAN'S NAME (Type) Timothy James Tehan, M.D.		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/21/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Ceme.	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR <i>Stewart</i>		25a. REC'D BY REGISTRAR DATE SEP 23 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles</i>		25c. REGISTRAR'S NAME Charles	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

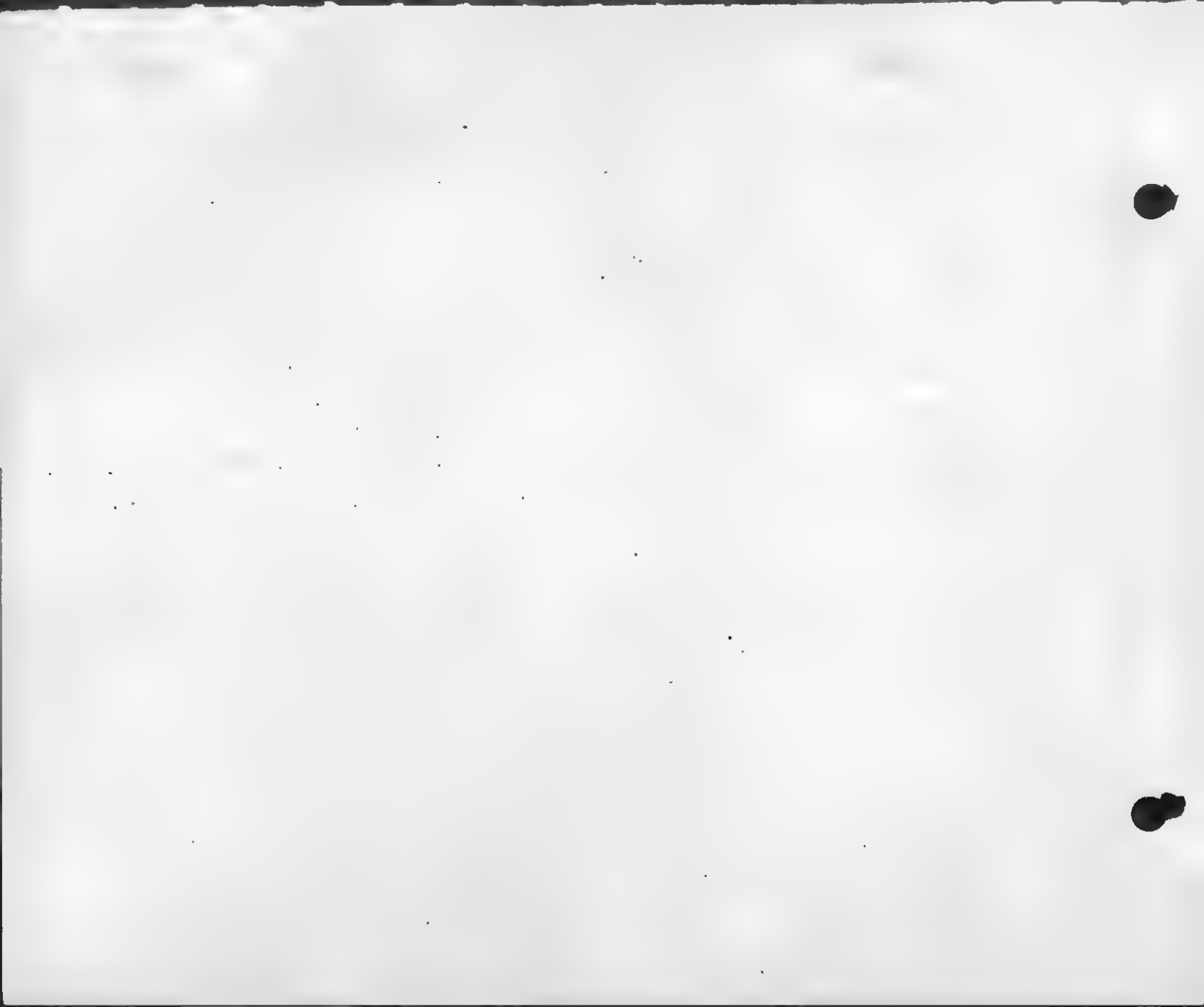
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1288

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs</u>		d. STREET ADDRESS <u>11727 College View Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Elizabeth Conrad</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Co. ca</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. AGE (In years last birthday) IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fayette City, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Matthew Posey</u>		14. MOTHER'S MAIDEN NAME <u>Rose Posey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-27760</u>	
17. INFORMANT <u>HUSBAND</u>		Address <u>11727 College View Dr, FARMERS S. S., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lobar pneumonia</u> (c) <u>None</u> DUE TO <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		22. DATE SIGNED <u>Sept 9, 1966</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SE</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Maryland</u>		2 USUAL RESIDENCE Where deceased lived, if institution, specify institution a. STATE <u>M.D.</u>	
b. CITY OR TOWN <u>Bethesda</u>		c. COUNTY <u>Montgomery</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If hospital, give street address) <u>Suburban Hosp</u>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First <u>Douglas</u> Middle <u>M.</u> Last <u>Cormack</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 13 1944</u>
9 AGE (lost birthday) yrs <u>21</u>		10 UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins <u>0</u>	
11 BIRTHPLACE State or foreign country <u>N.Y.</u>		12 PEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>DOUGLAS M. CORMACK</u>		14 MOTHER, MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <u>yes</u> Active duty		16 INFORMANT <u>DOUGLAS M. CORMACK SAME AS #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Transection Aorta</u> DUE TO (c) <u>Automobile Accident</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hit by car while walking with mother</u>	
21 TIME OF INJURY Month Day Year <u>10 PM Sept 9, 1966</u>	22 INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	23 PLACE OF INJURY Home for factory street off campus etc) <u>Home</u>	24 (City or town) (County) (State) <u>Bethesda Montgomery D.C.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. P. [Signature]</u> MD		22 DATE SIGNED <u>Sept 10, 1966</u>	
EXAMINER'S NAME Type <u>John S. P. [Signature]</u>		Address (Street, city, town or county) <u>1735 [Address]</u>	
23a BURIAL (CREMATION, REMOVAL, Specify)	23b DATE THEREOF <u>9/13/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>BRAINARD</u>	23d LOCATION (City or Town) (County) (State) <u>CRAWFORD N.Y.</u>
24 FUNERAL DIRECTOR <u>W W Chambers & Co</u> ADDRESS <u>1400 Chapin St NW Wash, D.C.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 15 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

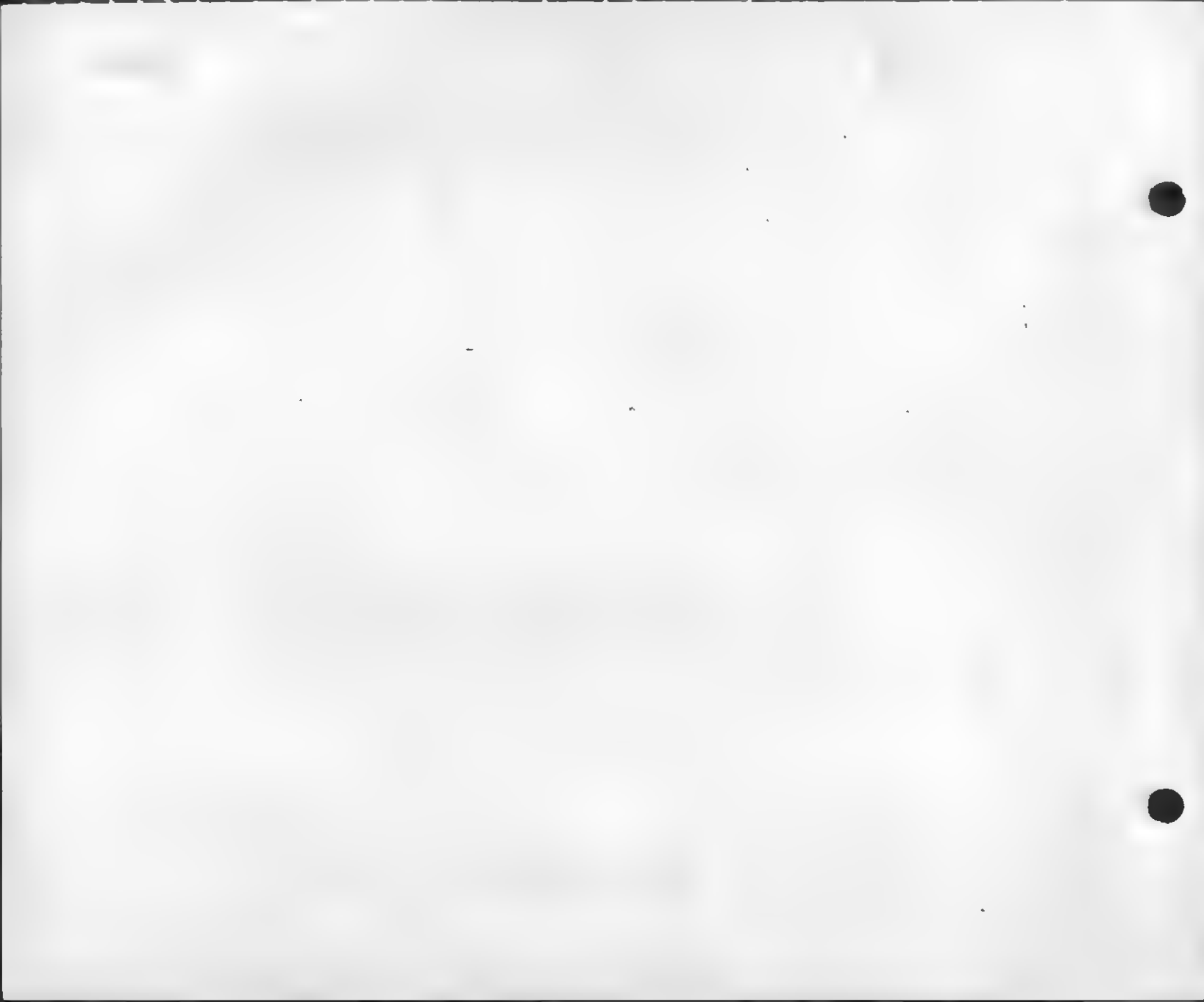
CERTIFICATE OF DEATH

12889

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY N 1b <u>2 1/2 yrs</u>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's</u>		d STREET ADDRESS <u>1115 1st St</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>James H. Orley</u>		4 DATE OF DEATH Month Day Year <u>Sept 15 1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-1-1914</u>
9 AGE (In years last birthday) <u>52</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>James H. Orley</u>	
14 MOTHER'S MARRIED NAME <u>Sarah C. Orley</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO		17 INFORMANT <u>Don Donald C. Crompton</u> Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sarcoma, diffuse, pulmonary bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-66</u> , 19 <u>66</u> , to <u>9-15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-14</u> , 19 <u>66</u> , and that death occurred at <u>1145</u> A.M., from causes and on the date stated above			
22a SIGNATURE <u>Donald L. Bucy</u>		22b. DATE SIGNED <u>9-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a BURIAL (CREMATION, REMOVAL) (Specify)	23b DATE THEREOF <u>9/18/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Elizah</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville Montg Md</u>
24 FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b REGISTRAR'S SIGNATURE <u>James Judge</u>		25c ADDRESS <u>Rockville Md</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1 PLACE OF DEATH a COUNTY <u>Maryland</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if inst. tut. or. Residence before admission) a STATE <u>D.C.</u> b COUNTY <u>Washington</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sumner</u>				d STREET ADDRESS <u>474-1st St. N.W.</u>			
3 NAME OF DECEASED (Type or print) First <u>Osceola</u> Middle <u>L.</u> Last <u>Creamer</u>				4 DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-29-88</u>	9 AGE (years) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11 BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Osceola L. Creamer</u>				14 MOTHER'S MAIDEN NAME <u>Martha L. Creamer</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or ink, war, If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>579-01-5539</u>		17 INFORMANT <u>Martha L. Creamer</u> Address <u> </u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1964</u> to <u>Sept 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1966</u> , and that death occurred at <u>4 p.m.</u> from causes and on the date stated above.							
22a SIGNATURE <u>Joseph J. Norton</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>9/17/66</u>	
22c PHYSICIAN'S NAME (Type) <u>Joseph J. Norton</u>				22d ADDRESS <u>716 1st St. N.W., Washington, D.C.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9-20-1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24 FUNERAL DIRECTOR <u>Joseph J. Norton's Sons, Inc.</u> <u>1170 Wisconsin Ave. N.W., Wash. D.C.</u>				25a REC'D BY REGISTRAR <u>SEP 23 1966</u>		25b REGISTRAR'S SIGNATURE <u> </u>	



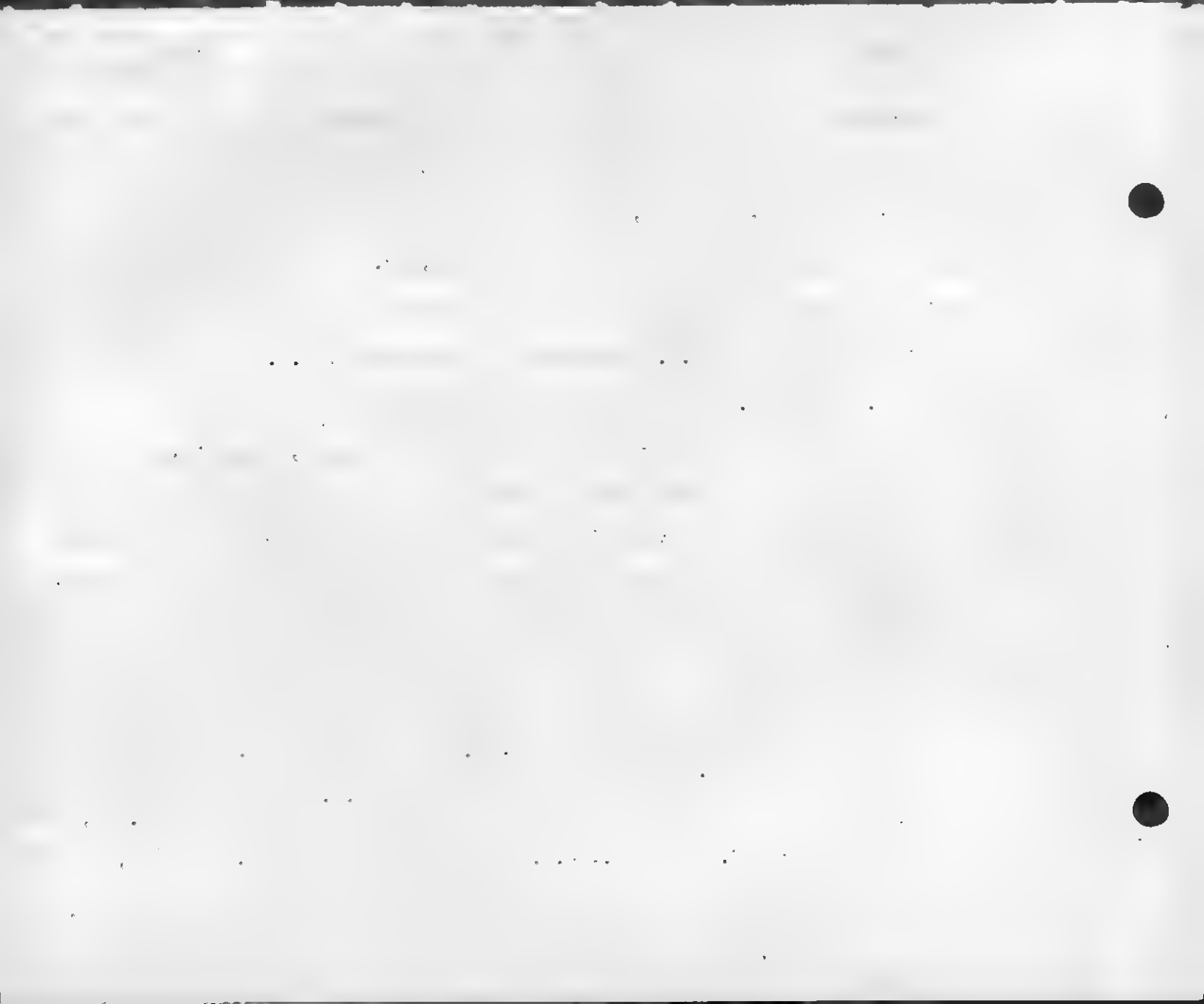
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12891

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		d. STREET ADDRESS 9505 Michael Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland															
3. NAME OF DECEASED (Type or print) Edwin		First		Middle Stanton		Last Crisp, Jr.		4. DATE OF DEATH Month September		Day 19		Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9 September 1934		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 32		Days 32		Hours 32	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Agent		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Edwin S. Crisp, Sr.						14. MOTHER'S MARDEN NAME Anna Willis									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 579-44-0141				17. INFORMANT The Medical Records				Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO (b) Compression of the spinal cord at C2-3 DUE TO (c) Hodgkin's disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 years															
INTERVAL BETWEEN ONSET AND DEATH 4 days															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that MD (this hospital) attended the deceased from Sept. 17, 1966 , to Sept. 19, 1966 , that he (we) last saw the deceased alive on Sept. 19, 1966 , and that death occurred at 10:45 , from the causes and on the date stated above.															
22a. SIGNATURE Herbert E. Kann, Jr., M.D.				22b. DATE SIGNED Sept. 20, 1966				22c. PHYSICIAN'S NAME (Type) Herbert E. Kann, Jr., M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/23/66				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) XXXX Prince Georges, Md.			
24. FUNERAL DIRECTOR Wilhelm Funeral Home				25a. REC'D BY REGISTRAR 4308 Suitland Rd. Suitland, Md.				25b. REGISTRAR'S SIGNATURE SEP 23 1966							



MARYLAND STATE DEPARTMENT OF HEALTH

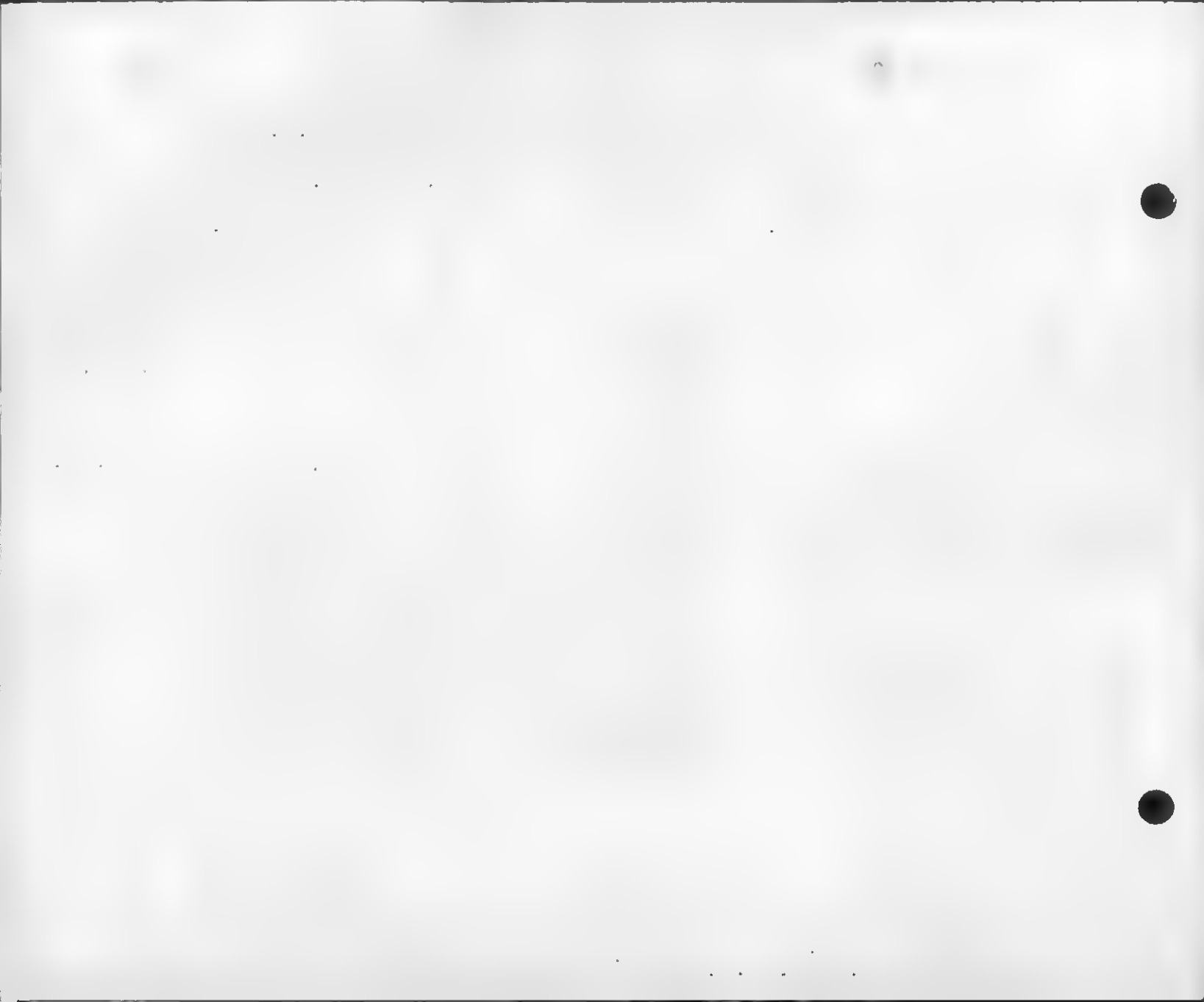
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12892

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh Spring</u> c. LENGTH OF STAY IN (b) d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <u>Shirland Nursing Home</u>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. of Col.</u> d. STREET ADDRESS <u>544 Lane Road, N.W.</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>S.</u> Last <u>Davis</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-11-1979</u>
9 AGE in years (last birthday) <u>87</u> yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR INDUSTRY 		11 BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Edward Heulings Savage</u>	
14 MOTHER'S MAIDEN NAME <u>Mary Nord</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
16 SOCIAL SECURITY NO <u>578-02-0532</u>		17 INFORMANT Address <u>Miss Dorothy L. Morrison - See item</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of Left Foot</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>36 days</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 23, 1966</u> to <u>Sept 25, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 23, 1966</u> and that death occurred at <u>6:58 AM</u> from causes and on the date stated above			
22a SIGNATURE <u>Neil P. Campbell</u>		22b DATE SIGNED <u>9/25/66</u>	
22c PHYSICIAN'S NAME (Type) <u>Neil P. Campbell</u>		22d ADDRESS <u>1629 Columbia Rd -</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9-28-1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		23d LOCATION (City or Town) (County) (State) <u>Arlington Va</u>	
24 FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u> <u>130 Wisconsin Ave. N.W.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>	
25b REGISTRAR'S SIGNATURE 		 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12893

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>2 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1301 Tenthon Road</u>		d. STREET ADDRESS <u>1301 Tenthon Road</u>	
3 NAME OF DECEASED (Type or print) <u>HARRY J Davis</u>		4 DATE OF DEATH <u>Sept 22 1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-30-1891</u>
9 AGE <u>75</u> years (last birthday)		10 IF UNDER 1 YEAR Months Days	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>John L. Davis</u>		14 MOTHER'S MAIDEN NAME <u>Anna Brown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>218-03-3764</u>	
17. INFORMANT <u>5927 Address: 1111 1st St. N.E. Washington, D.C.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency Failure</u> DUE TO <u>Electrolyte Imbalance</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <u>Cardiac Insufficiency Failure</u> (b) <u>Electrolyte Imbalance</u> (c) <u>Cardiac Insufficiency Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Arteriosclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 19 <u>66</u> , to <u>7-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-22</u> , 19 <u>66</u> , and that death occurred at <u>3:45</u> A.M., from causes and on the date stated above			
22a SIGNATURE <u>William Henry Kilgus</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9-26-1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Md</u>
24 FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellacott City, Md</u>		25a REC'D BY REGISTRAR DATE	
		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.



12894

b. COUNTY *Montgomery*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

• IS RESIDENCE ON A FARM?
YES ☐ NO ☒

204 Pa. 227 1904

Yield

9. AGE (In years) (IF UNDER 1 YEAR) IF UNDER 24 HRS.

last birthday)	Months	Days	Hours	Min
----------------	--------	------	-------	-----

12. CITIZEN OF WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME _____

Palma Boise

17. INFORMANT
Oscar W. Isaturo

Address
2204 Parker Ave.
Wheaton, Md.

INTERVAL BETWEEN
ONSET AND DEATH

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.



PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AN AUTOPSY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONTINUED)		PERFORMED?
YES	NO	

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF OTHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Hour m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town, County) (State)
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21. I certify that (I) (this hospital) attended the deceased from. January 19, 1947, to July 4, 1947, that (I) (we) last saw the deceased alive on July 4, 1947 and that death occurred at 10 M. from the causes and on the date stated above.

22a. SIGNATURE  

22c. PHYSICIAN'S NAME (Type) William H. Sig

SERIAL	CREMATION	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)

3 incl Sent 8 1966 date of Heaven BERRY com Silver Spring, Md.

25a FUNERAL DIRECTOR'S SIGNATURE *Clark E. Wisner* ADDRESS *1404 1/2 Ave.* 25b REC'D BY REG STRAR 25b REGISTRAR'S SIGNATURE *CEB*

Warner E. Hapner, Inc. Silver Spring, Md. DATE SEP 1 1966 J. Walter Judge

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1592

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and to any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN BETHESDA c. R. R. 6417 CAMROSE TERRACE		2 USUAL RESIDENCE Where deceased lived if different from above a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN BETHESDA d. STREET ADDRESS 6417 CAMROSE TERRACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First Middle Last AGNES T. DEVEREAUX		4 DATE OF DEATH Month Day Year SEPT 25 19 66	
5 SEX FEMALE 6 COLOR OR RACE CAU 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH 2-13-1898 9 AGE 68 10 FUNDING YEAR 7 11 FUNDING MONTH 12 12 FUNDING DAY 12		13 FATHER'S NAME ANDREW J. KANE 14 MOTHER'S MARRIAGE NAME Mary Ellen Murphy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16 SOCIAL SECURITY NO Unknown 17 INFORMANT MRS. ROSEMARY CORBIN Address 5530 Johnson Bethesda, Md.		18 CAUSE OF DEATH (Enter in one cause per line in (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost (b) Cardio Vascular Disease (c) Obesity	
19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Obesity	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22 ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL		23 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md.	
23a BURIAL OR CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 9-27-66	
23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d LOCATION (City or town) (County) (State) Silver Spring, Maryland	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR SEP 1966 25b REGISTRAR'S SIGNATURE Charles	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12596

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE OHIO b. COUNTY Montgomery			
b. CITY OR TOWN Woodacres write RURAL and give nearest town				c. CITY OR TOWN Dayton write RURAL and give nearest town			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5918 Harwick Road				e. STREET ADDRESS 1742 Radcliffe Rd.			
3. NAME OF DECEASED Type & print ELLA M. DEWITT				4. DATE OF DEATH Month Sept. Day 18, Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 21, 1879	
9. AGE 86		10. BIRTHPLACE Ohio		11. BIRTHPLACE (For foreign birth) USA		12. COUNTRY OF WHAT USA	
13. FATHER'S NAME Charles H. Gunter				14. MOTHER'S MAIDEN NAME Harriet Pinkerton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, unknown, If yes give war, grades, service) No				16. SOCIAL SECURITY NO. 292-14-8229		17. INFORMANT Woodacres, Bethesda, Md. George M. Lohnes-Son-5918 Harwick Rd.	
18. CAUSE OF DEATH (Enter the cause pertinent to the death) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost Cardio Vascular Disease DUE TO 4 years				INTERVAL OF SEEN ONSET AND DEATH Sudden			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) in-law				19. WAS A TAPSEY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street city, town or county) Bethesda, Md.				22. DATE SIGNED Sept. 18, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 9/19/66		23c. NAME OF CEMETERY OR CREMATORY Germantown Cemetery		23d. LOCATION (City or town) (County) (State) Germantown Ohio	
24. FUNERAL DIRECTOR Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. RECD BY REGISTRAR SEP 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge							

de

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

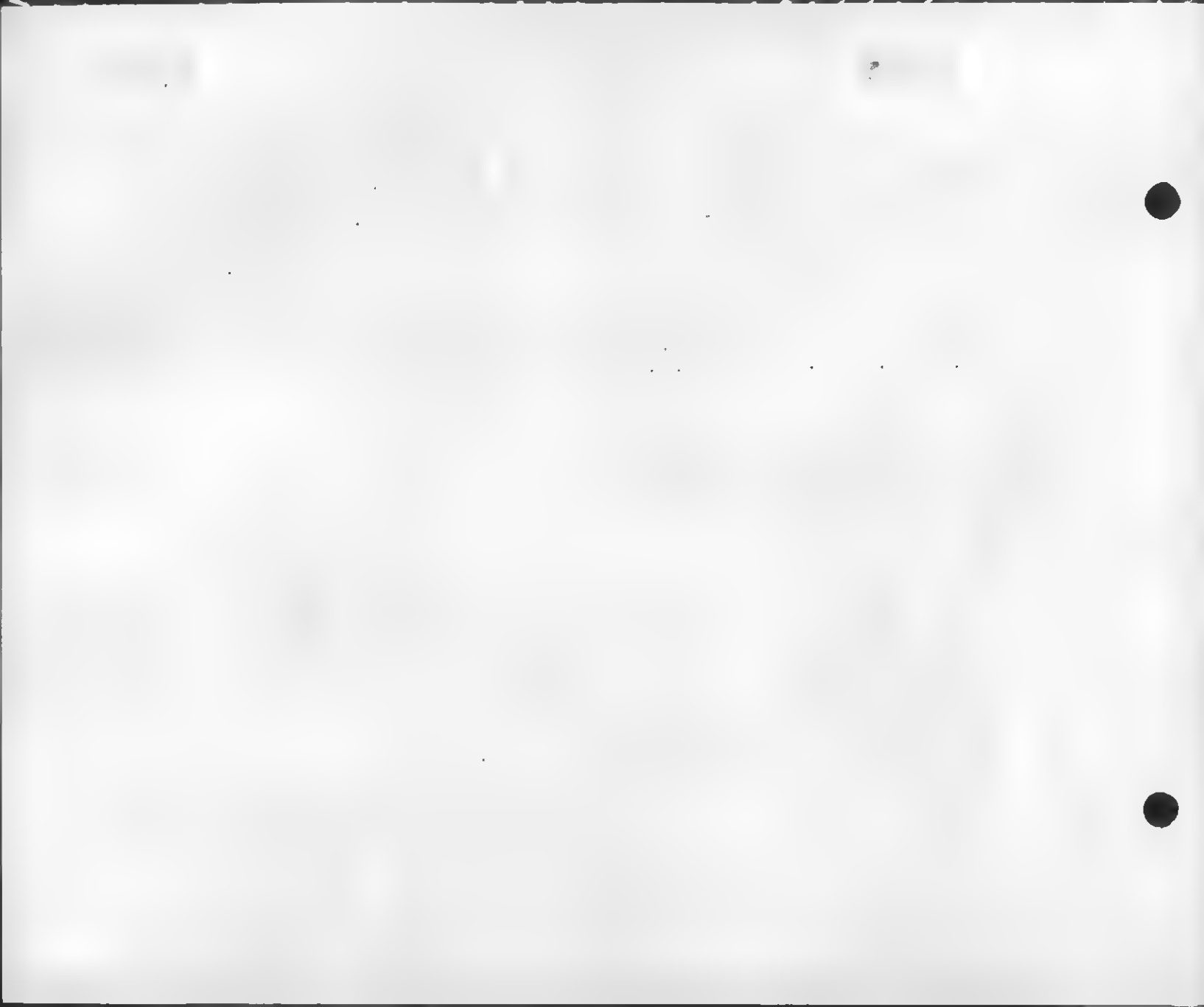
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12897

CERTIFICATE OF DEATH

12897

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Silver Spring Nursing Home		d. STREET ADDRESS 3006 Laurel Avenue	
3 NAME OF DECEASED (Type or print) First Stanley Middle A. Last Diana		4 DATE OF DEATH Month Sept. Day 18, Year 19 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 31, 1902
9 AGE (in years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working hours) Ret. Asst. Dist. Comm. U.S. Government		11 BIRTHPLACE (County & State, or foreign country) New York	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John Diana	
14 MOTHER'S MAIDEN NAME Mary Aimee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO none		17 INFORMANT Mrs. Genevieve C. Diana Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH. 10 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from 7-18-66 , 19 66 , to 9/18 , 19 66 , that (I) (we) last saw the deceased alive on 7/16 , 19 66 , and that death occurred at 4:40 P.M., from causes and on the date stated above			
22a SIGNATURE Francis Gasch		22b DATE SIGNED 9/18/66	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL (CREMATION, REMOVAL) (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/23/66	Holy Cross	Brooklyn, N. Y.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR DATE SEP 21 1966	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

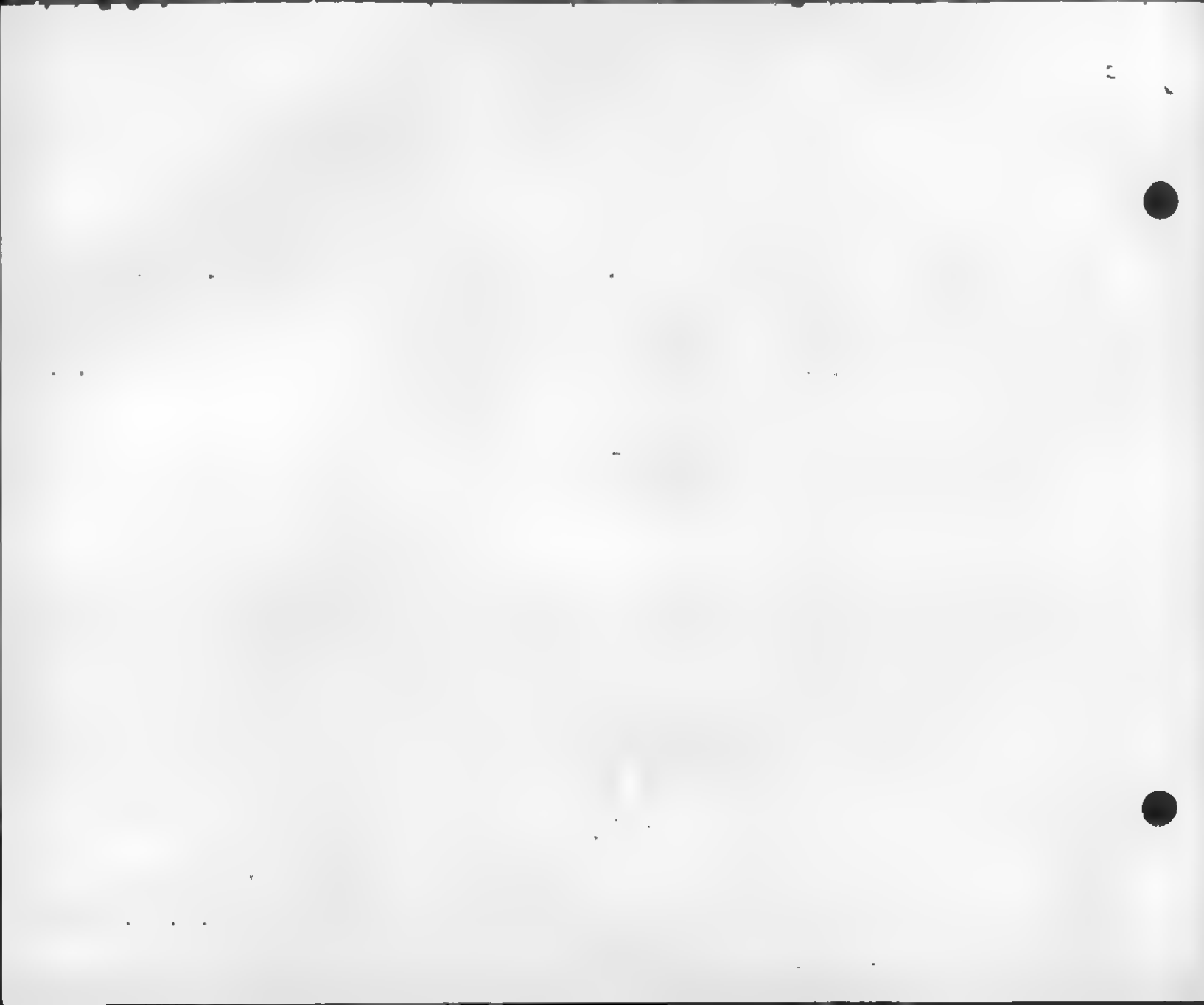
CERTIFICATE OF DEATH

12895

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN b ??	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) 4516 Gladwyne Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last CHRISTABEL F. DODGE		4 DATE OF DEATH Month Day Year Sept. 21, 19 66	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Dec. 23, 1895
9 AGE (in years last birthday) 70		10 FUNDING YEAR Month Days Hours Min. 8 28	
11a US AL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt - Retired		11b KIND OF BUSINESS OR INDUSTRY Illinois	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Benjamin Franklin	
14 MOTHER'S MAIDEN NAME Mary Dawtel		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 495-30-8351		17 INFORMANT Son Herbert W. Dodge Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH few instants - sev. hrs		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus since 1944	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f (City or town) (County) (State)		21 I certify that () (this hospital) attended the deceased from 12/30, 1955 , to 9/21, 1966 , that (I) (we) last saw the deceased alive on 8/26, 1966 , and that death occurred at 11 A.M. , from causes and on the date stated above	
22a SIGNATURE Michel M. Healy M.D.		22b DATE SIGNED 9-21-66	
22c PHYSICIAN'S NAME (Type) MICHEL M. HEALY		22d ADDRESS Washington Clinic Washington, D. C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9/23/1966	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or town) (County) (State) Suitland P.G. Co. Maryland
24 FUNERAL DIRECTOR Robert A. Pumphrey		25a REC'D BY REGISTRAR DATE SEP 21 1966	
ADDRESS Bethesda, Maryland		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and be sent, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12805

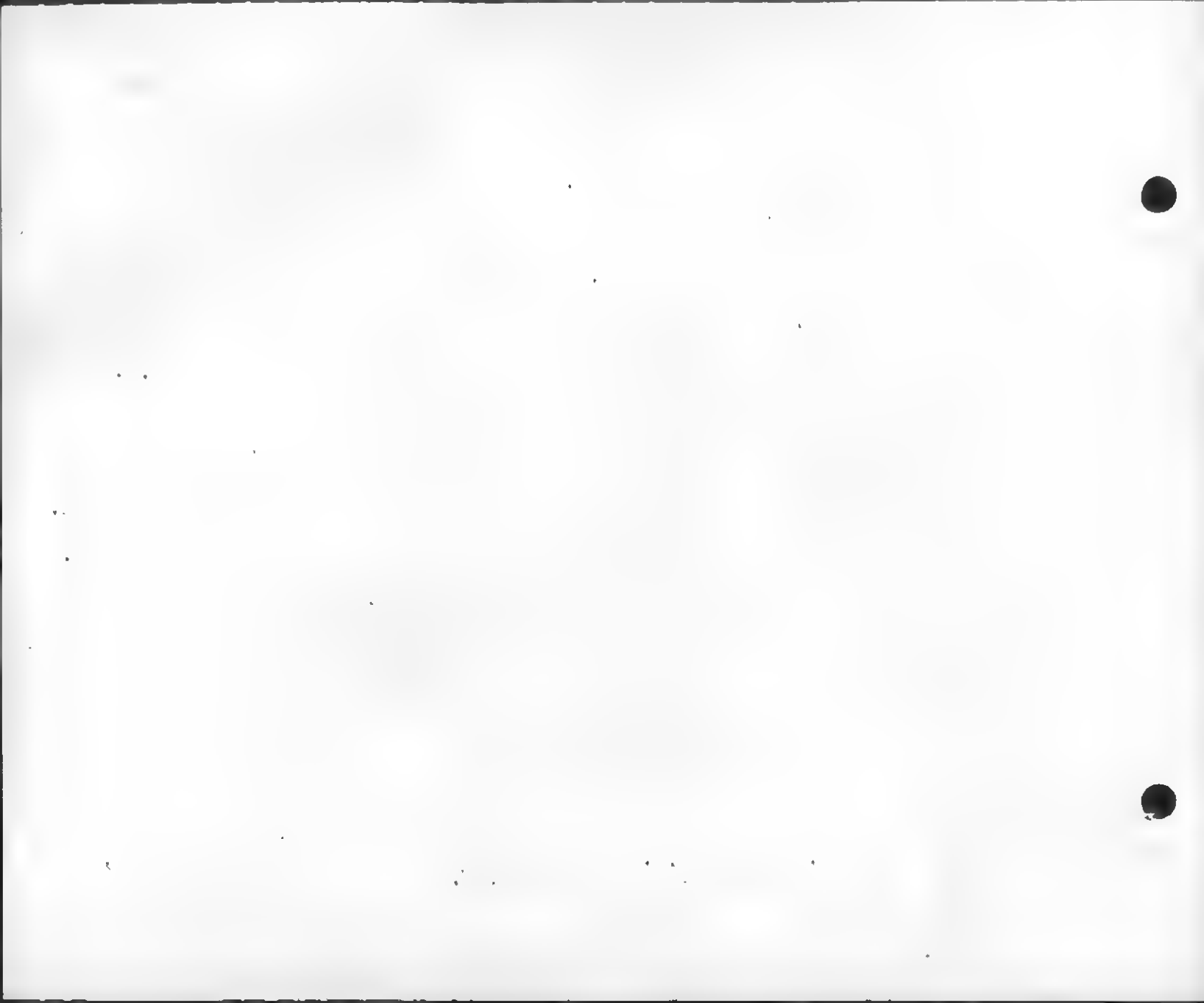
12890

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>5 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>10109 Greeley Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED Type: <u>person</u> First <u>Ella</u> Middle <u>May</u> Last <u>Donwart</u>				4 DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1966</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Cauc.</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4/4/98</u> 95	
9 AGE 1. years last birthday) <u>71</u> 68 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13 FATHER'S NAME <u>Michael H. Janbert</u>			
14 MOTHER'S MAIDEN NAME <u>Lillie J. Wilhelm</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>			
16 SOCIAL SECURITY NO. <u>None</u>				17 INFORMANT <u>Mrs. James L. Rankin</u> Address <u>10109 Greeley Ave. S. S., Md.</u> <u>Daughter</u> <u>same</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial disease</u> DUE TO (b) <u>Chronic congestive heart failure</u> DUE TO (c) <u>Generalized arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>6 yr.</u> <u>years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>None</u>							19 WAS AN OPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>None</u>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u> EXAMINER'S NAME (Type) <u>1919 Seminary Rd., Silver Spring, Md.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street city town, or county) <u>September 9, 1966</u>			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Sep. 14, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>East Harrisburg Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Harrisburg, Pennsylvania</u>	
24 FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a REC'D BY REGISTRAR <u>SEP 11 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



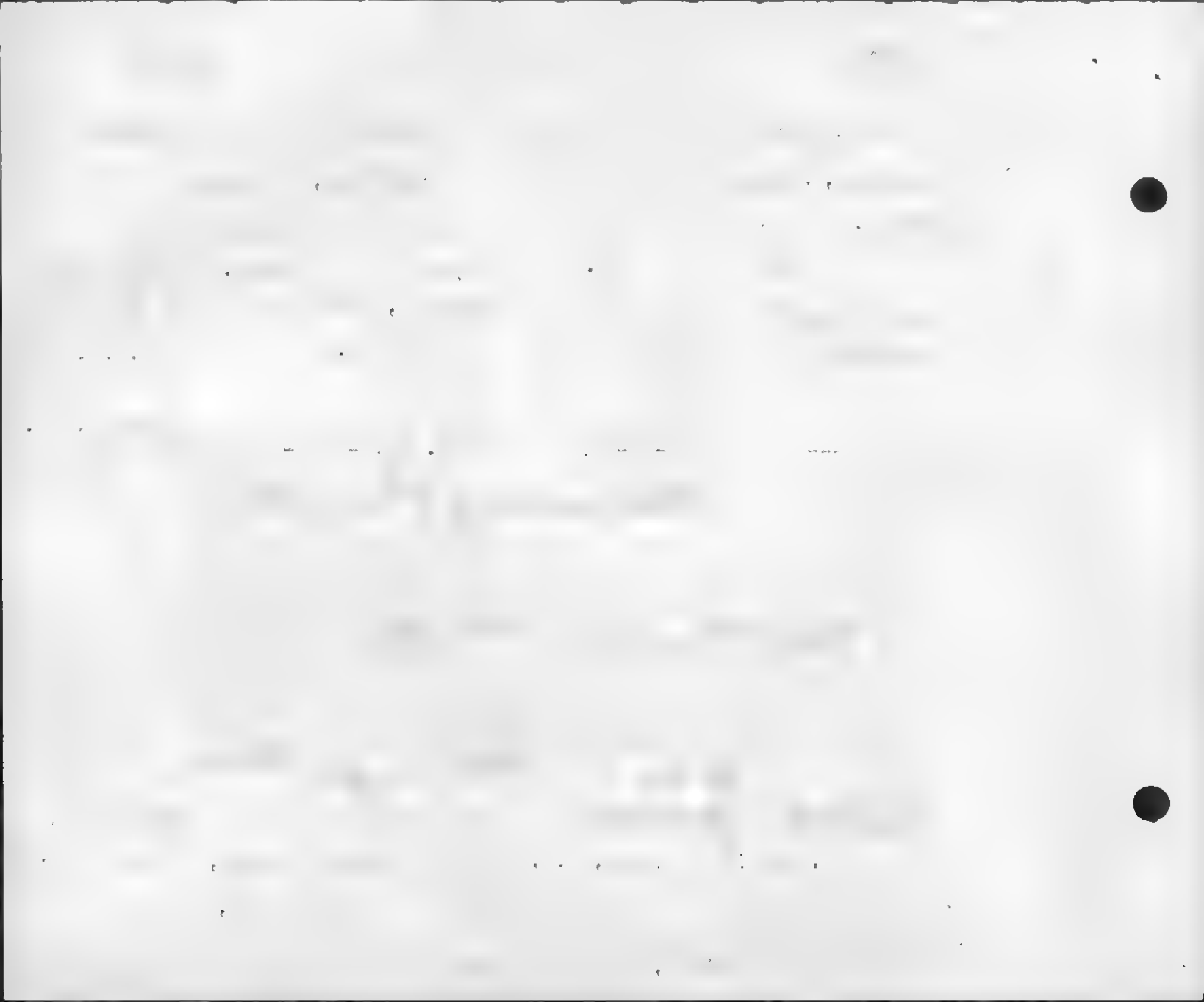
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12910

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12418 Seven Locks Road		d. STREET ADDRESS 12418 Seven Locks Road	
3. NAME OF DECEASED (Type or print) Emma		4. DATE OF DEATH Month Sept. Day 29 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-5813	
17. INFORMANT Earl E. Dove- Son-		Address Rockville, Md. 4800 Oxbow Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + obesity		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/2/66 , 19__, to 9/29/66 , 19__, that (I) (we) last saw the deceased alive on 9/21/66 , 19__, and that death occurred at 20 M, from the causes and on the date stated above.			
22a. SIGNATURE Patrick Jameson		22b. DATE SIGNED 9/29/66	
22c. PHYSICIAN'S NAME (Type) Dr. Patrick Jameson, M.D.		22d. ADDRESS 11718 Georgia Avenue, Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town or county) (State) Rockville, Maryland
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR OCT 3 1966 25b. REGISTRAR'S SIGNATURE A A	
Address 1331 Rockville Pike		Address Rockville, Maryland 20852	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12901

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Yineland</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>25 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>				e. STREET ADDRESS <u>S. Myrtle ST.</u>			
3. NAME OF DECEASED (Type or print) <u>Eleanor E. Dubinsky</u>				4. DATE OF DEATH <u>9 - 25 - 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-07</u>	
				9. AGE (In years last birthday) <u>59</u> yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Frederick Meyerholz</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- -</u>				16. SOCIAL SECURITY NO. <u>155-36-5672</u>		17. INFORMANT <u>Mrs. George D Becker - Bowie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>SUPPURATIVE PYELONEPHRITIS</u> DUE TO (c) <u>CHRONIC RENAL FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>25 Days</u>			
PART II. OTHER SIGNIF. CANT COND. TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC RENAL FAILURE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/30/66</u> to <u>9/25/66</u> that (I) (we) last saw the deceased alive on <u>9/24</u> 19 <u>66</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>DR. J. GAWLER</u>				22d. ADDRESS <u>1507 Univ Blvd, HMTS, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1</u>		23b. DATE THEREOF <u>9-26-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Vineland, N.J.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. RECD BY REGISTRAR <u>E</u>		25b. REGISTRAR'S SIGNATURE	
1300 Wisconsin Ave. N.W. Washington, D.C.				DATE <u>9-25-66</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



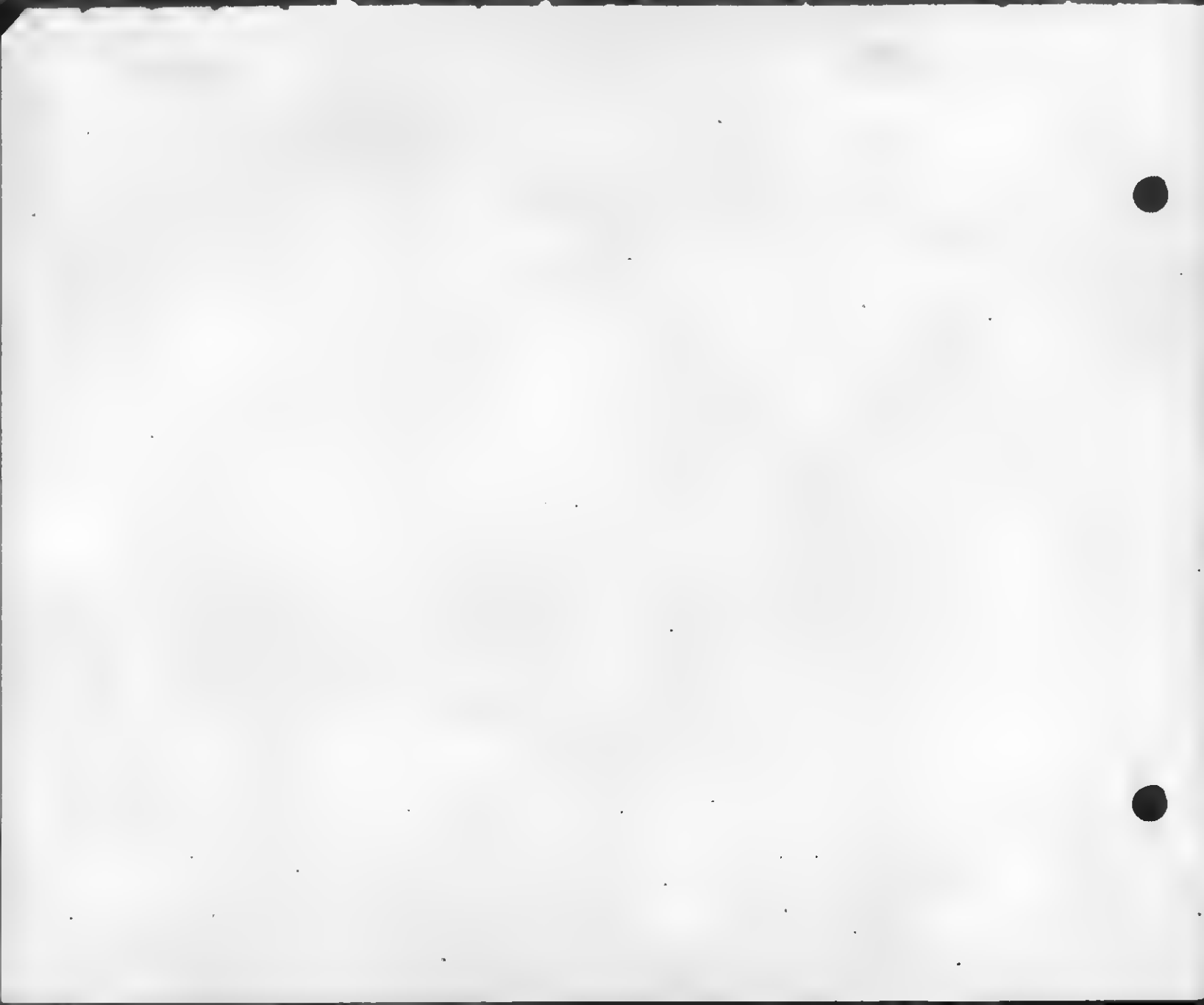
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12902

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRG HOME SILVER SPRING</u>		e. STREET ADDRESS <u>4626 KNOX RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EDWARD DUDLEY</u>		4. DATE OF DEATH Month Day Year <u>SEPT 3 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1877</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Dudley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dudley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>William H. Dudley (son)</u>		Address <u>254 Lathrop St. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>9/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/1/66</u> 19 <u>66</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>9/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Bartonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <u>William H. Dudley</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12903

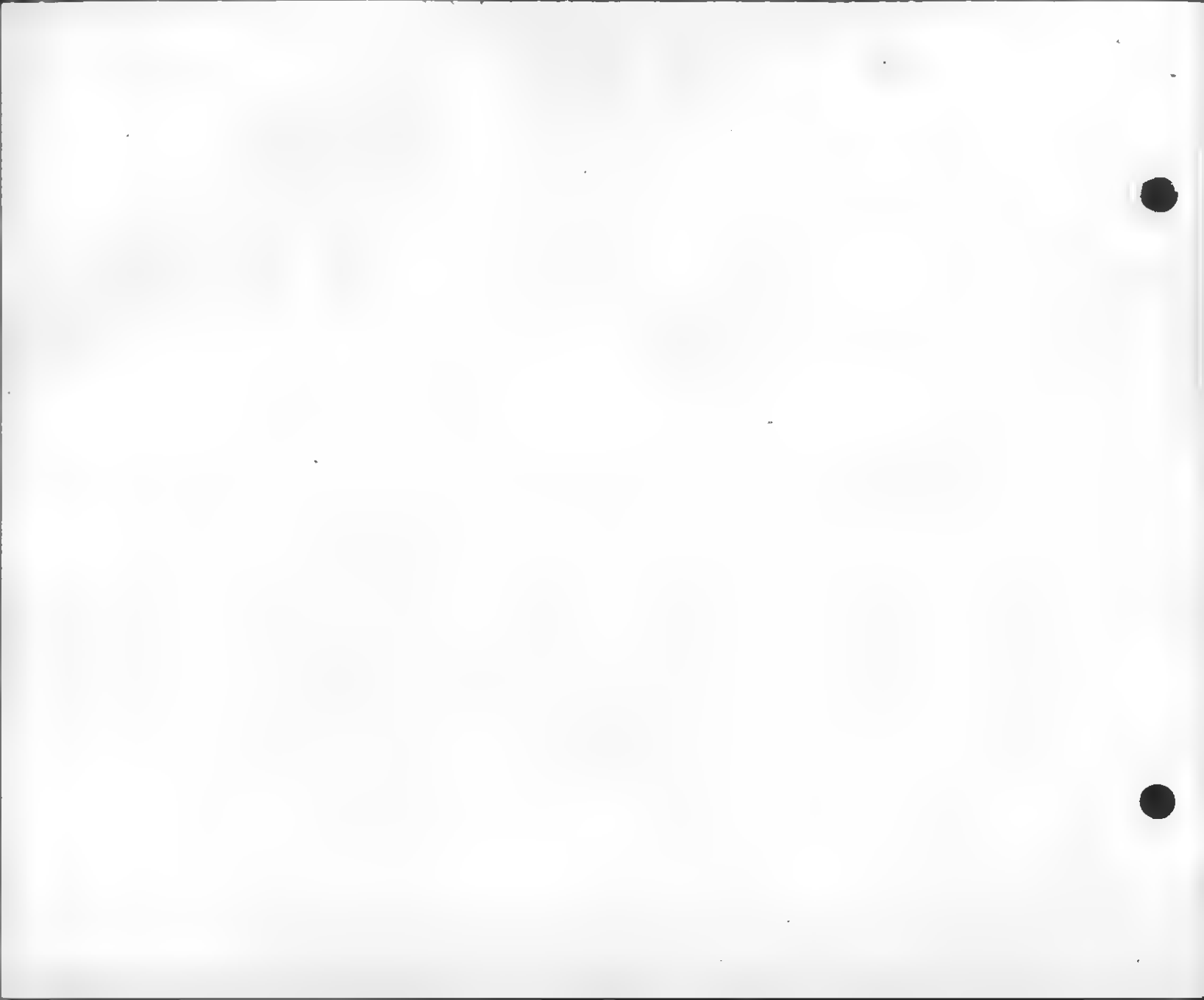
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word pending in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit if the body is to be transported to a funeral home or to a funeral home and in any event within 72 hours after death. If the body is to be buried, cremated, or removed to a cemetery, the body should be transported to the place of final disposition within 72 hours after death.

PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in Residence before death) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest city) <u>Rockville</u>		c LENGTH OF TIME IN b <u>10 A</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lumber Shed - Baltimore Ave</u>		d STREET ADDRESS <u>No fixed address</u>	
3 NAME OF DECEASED (True or print) <u>Carl L. Durbin</u>		4 DATE OF DEATH <u>Sept 15 1966</u>	
5 SEX <u>Male</u>	6 CO OR OR RACE <u>W</u>	7 NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>9/26/13</u>
9 AGE (last birthday) <u>52</u>		10 FINDER YEAR (Months, Days, Hours, Mins) <u>11 19</u>	
11 BIRTHPLACE (State or foreign country) <u>Lorainville Ohio</u>		12 COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>LEO S. DURBIN</u>		14 MOTHER'S MAIDEN NAME <u>FRANCIS PARKER</u>	
15 WAS A MEMBER OF U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (If yes, give date of service) <u>Yes WW II</u>		16 SOCIAL SECURITY NO. <u>Unknown</u>	
17 INFORMANT <u>Lambert Durbin - Brother</u>		18 ADDRESS OF INFORMANT <u>Rockville, Md</u>	
19 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY: <u>4201 Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>	
(a) IMMEDIATE CAUSE <u>Coronary Thrombosis</u>		(b) DUE TO <u>12 hr.</u>	
(c) DUE TO <u>12 hr.</u>		(d) DUE TO <u>12 hr.</u>	
20a EXTERNAL CAUSE (If primary, check <input checked="" type="checkbox"/> or contributing, check <input type="checkbox"/> <u>Chronic Alcoholism</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Chronic Alcoholism</u>	
20c TIME OF INJURY (Month, Day, Year) <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda, Md.</u>		20f (City or town) (County) (State) <u>Bethesda, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22 DATE SIGNED <u>9/15/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ADDRESS (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9-19-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>SEP 20 1966</u>	
25b REGISTRAR'S SIGNATURE <u>James J. Jones</u>		25c REGISTRAR'S SIGNATURE <u>James J. Jones</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 - MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12904

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN Olney (If not a city or town, write RURAL and give nearest town)		c LENGTH OF STAY 16 CITY OR TOWN Silver Spring (If not a city or town, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION Montgomery General Hospital		4 STREET ADDRESS 14920 Peach Orchard Rd.	
3 NAME OF DECEASED First Oden Middle Dwyer Last Dwyer		4 DATE OF DEATH Month 9 Day 19 Year 66	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/18/86
9 AGE in year (last birthday) 80 yrs		10 FUNDING YEAR Month 11 Days 15 hours 15 min	
11 ALIEN STATUS (Give kind of work done during most of working life, even if retired) Welfare - 15 yrs.		12 KIND OF BUSINESS OR INDUSTRY Welfare - 15 yrs.	
13 BIRTHPLACE (State or foreign country) Md.		14 CITIZEN OF WHAT COUNTRY? USA	
15 FATHER NAME unknown		16 MOTHER'S MAIDEN NAME unknown	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? no		18 SOCIAL SECURITY NO 212-18-9599T	
19 INFORMANT Address Neice & Personal effects., Olney, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) to fall at home DUE TO (b) to fall at home Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) to fall at home			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a):			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? no		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 3:30 pm 9-19 19 66		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) Silver Spring Montg Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-20-1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County)	
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 9/23/66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Highland, Md.	
24. FUNERAL DIRECTOR F.C. Higginbotham ADDRESS Willicott City, Md.		25a. REC'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE Philip C. Higginbotham			



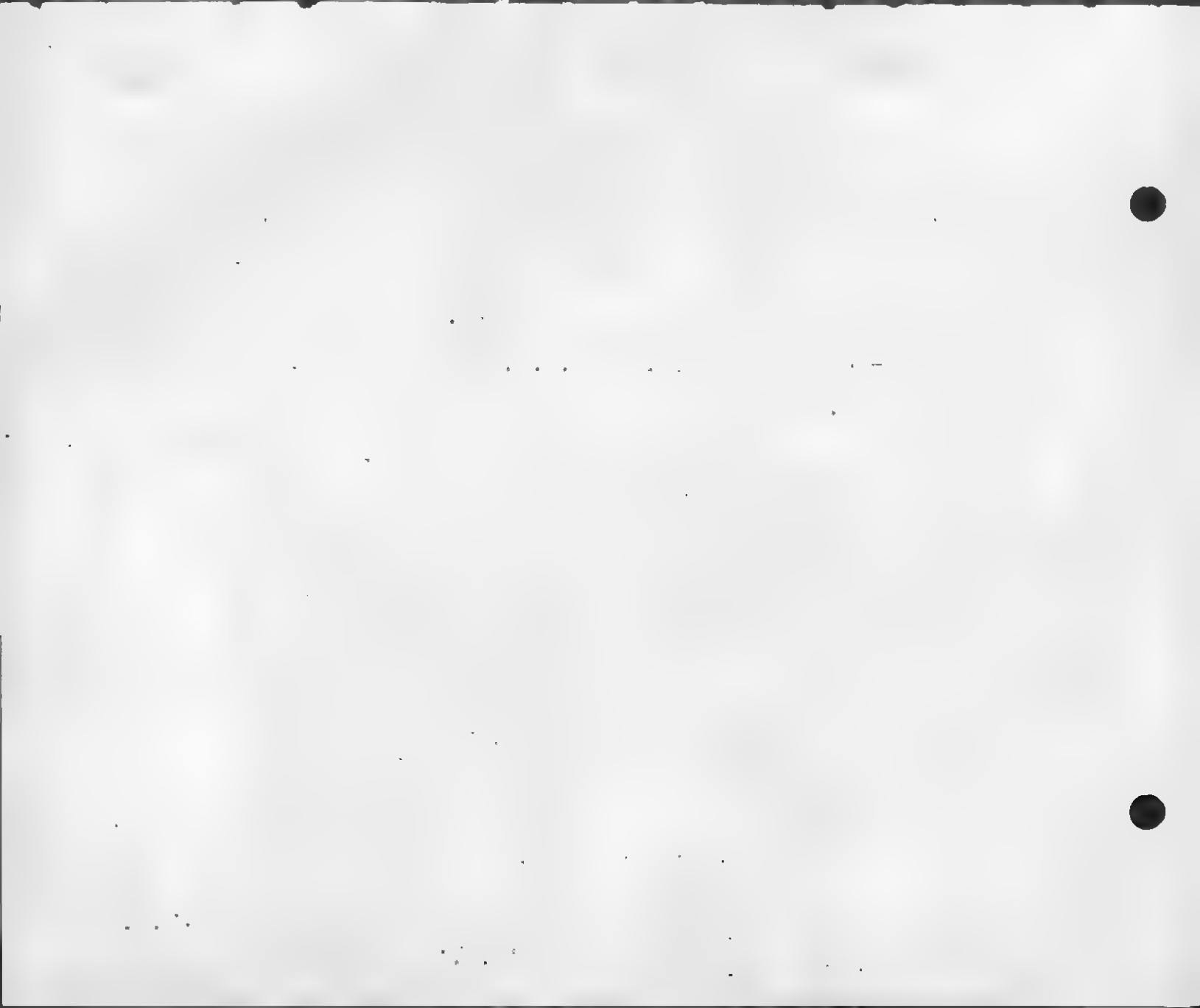
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12905

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Ebels		4. DATE OF DEATH Month Day Year 19 9 19	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 19, 1891
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) Months Days Hours Min. 8 8 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-WHITE HOUSE U.S. GOV'T		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME CHARLES E. EBEL	
14. MOTHER'S MAIDEN NAME MARIE EGLOFF		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARIE E. SMITH-SANDY SPRING, MARYLAND	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal of Pulmonary Edema</u> DUE TO <u>Chronic heart failure</u> DUE TO <u>Coronary artery disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u> <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 9 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/26/66</u> , 19 <u>66</u> , to <u>9/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> , 19 <u>66</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis X. Richardson</u>		22b. DATE SIGNED <u>9/19/66</u>	
22c. PHYSICIAN'S NAME (Type) Francis X. Richardson, M.D.		22d. ADDRESS <u>1141 N. ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF <u>9/22/1966</u>	23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR HYSONG FUNERAL HOME		25a. REC'D BY REGISTRAR DATE <u>9/19/66</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12906

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN ID 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2013 Chapman Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Robert Thomas Eicholtz		4. DATE OF DEATH September 30 1966		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 May 1910		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY County Government				11. BIRTHPLACE (County & State, or foreign country) Philippine Islands				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William W. Eicholtz				14. MOTHER'S MAIDEN NAME Lucretia Morgan				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII & Korean				16. SOCIAL SECURITY NO. 577-30-5597		17. INFORMANT Medical Records, The Clinical Center, Bethesda, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO (b) Undifferentiated Lymphoma DUE TO (c) decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exogenous compression of common bile duct with hepatocellular 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												INTERVAL BETWEEN ONSET AND DEATH 1 week 11 months			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that XX (this hospital) attended the deceased from Sept. 15 , 19 66 , to Sept. 30 , 19 66 , that XX (we) last saw the deceased alive on Sept. 30 , 19 66 , and that death occurred at 905 M. from the causes and on the date stated above.															
22a. SIGNATURE Martin H. Cohen				22b. DATE SIGNED 30 Sept. 1966				22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, MD				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR W. H. Hutterman				ADDRESS		25a. REC'D BY REGISTRAR OCT 4 1966				25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b Silver Spring
d. STREET ADDRESS 9419 Wire Avenue
e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Montgomery
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 9419 Wire Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Lolita Gladys Eschenburg
First Middle Last
4. DATE OF DEATH Sept 30 1966
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 18 May 1900
W DDWED ☐ DIVORCED ☐ 9. AGE (in years last birthday) 66 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (County & State, or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? yes

13. FATHER'S NAME Donald Redman
14. MOTHER'S MAIDEN NAME Edith MacCordy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 128-097231
17. INFORMANT Charles J. Eschenburg Address Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, uterus
1. X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus ASHD

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Aug 19 1963
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 9-27-66 to 9-30-66, that (I) (we) last saw the deceased alive on 9-27-66, and that death occurred at 3A.M. from the causes and on the date stated above.

22a. SIGNATURE G. F. Sangstack M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9/30/66
22c. PHYSICIAN'S NAME (Type) George F. Sangstack 22d. ADDRESS 9241 Columbia Blvd, S. 1 Spr. Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10-3-66 23c. NAME OF CEMETERY OR CREMATORY Arlington National 23d. LOCATION (City, town or county) (State) Arlington Va.

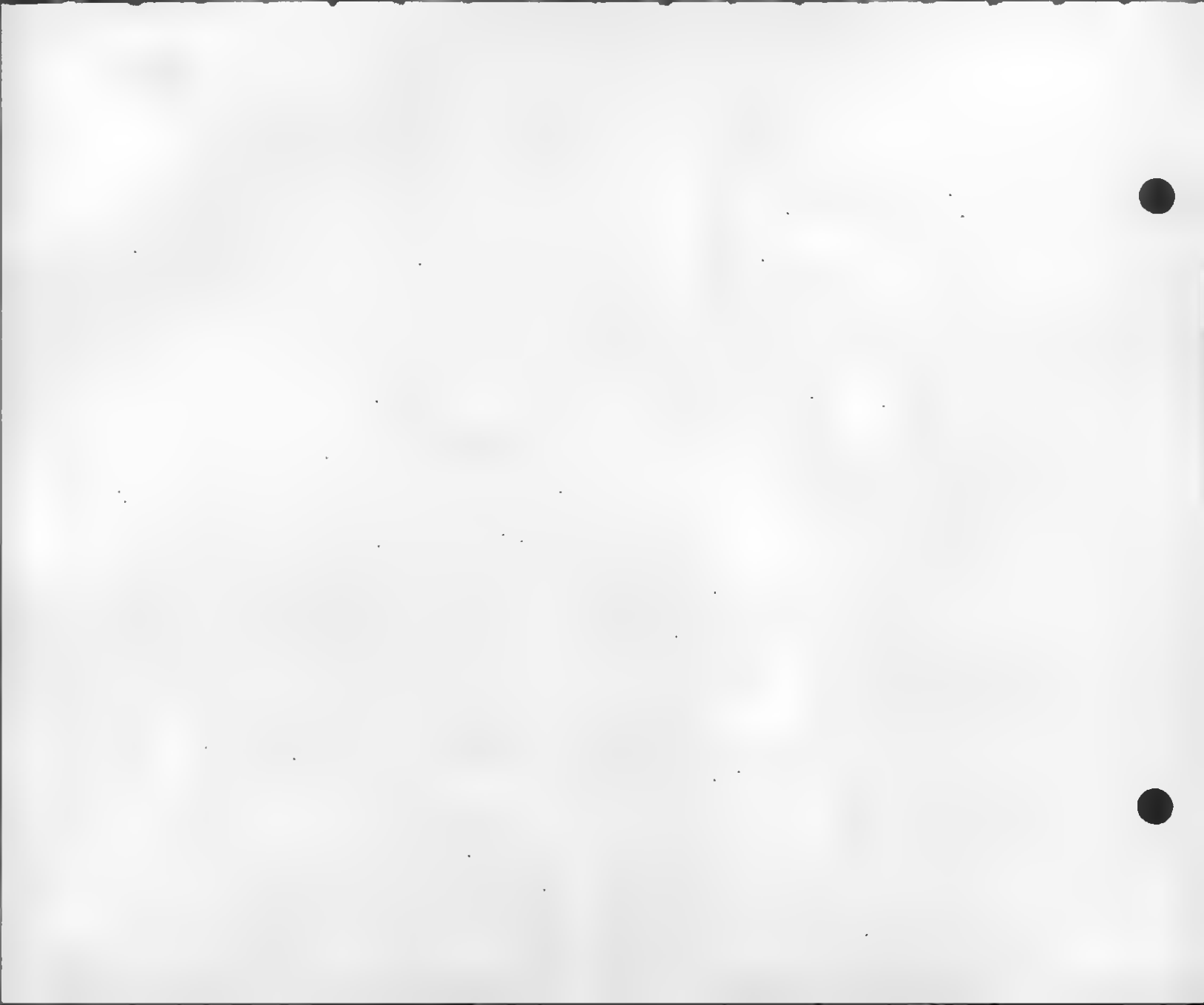
24. FUNERAL DIRECTOR W. C. CHAMBERS COMPANY ADDRESS Riverdale, Md. 25a. REC'D BY REGISTRAR DATE 25b. REGISTRAR'S SIGNATURE

1911

12010

1

VR A15 (4)
20M 1/65



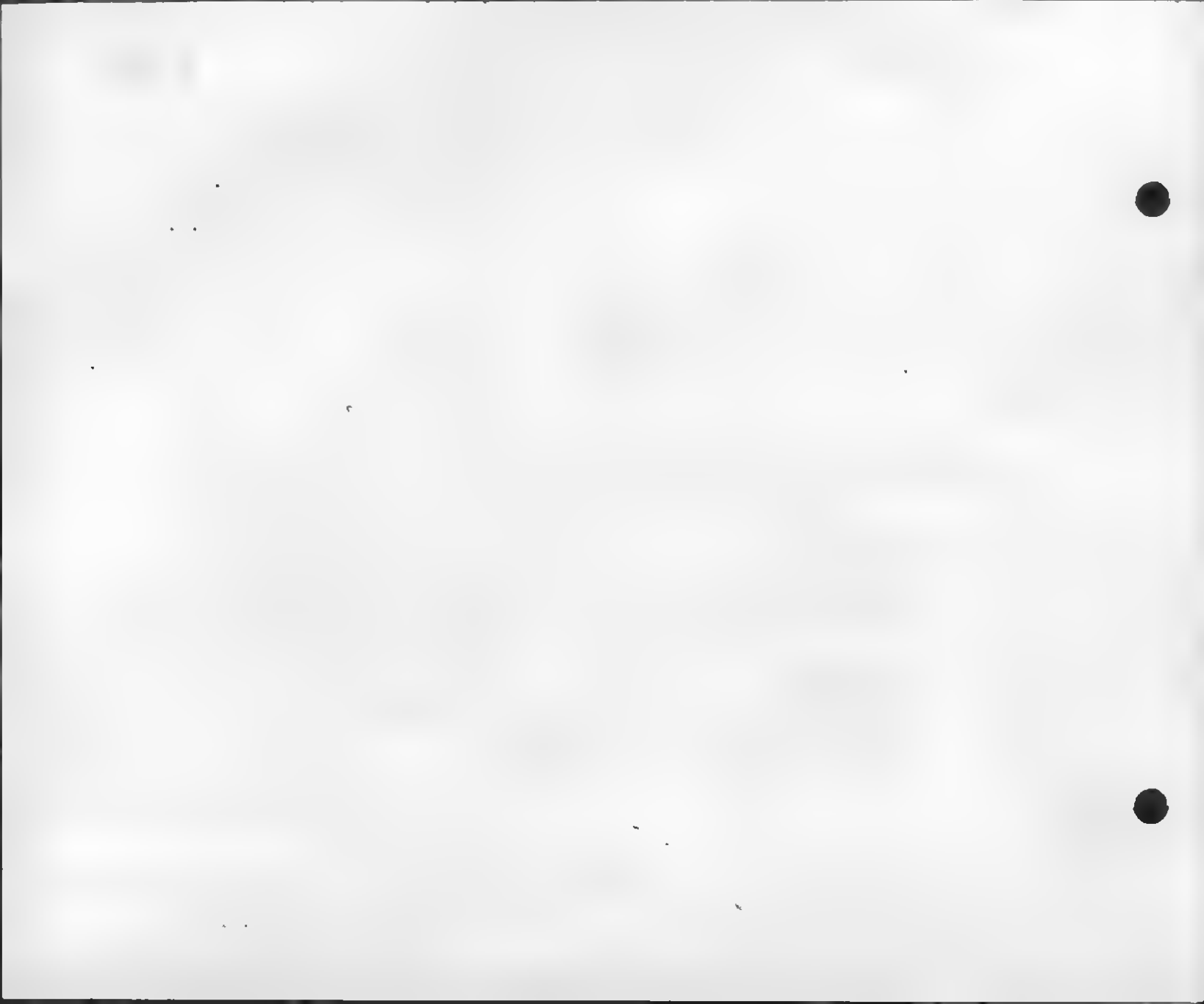
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		c LENGTH OF STAY in 1b <u>2 1/2</u>	
d NAME OF HOSPITAL OR INSTITUTION (If at in hospital, give street address) <u>"</u>		e STREET ADDRESS <u>"</u>	
3 NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Walter V. Ferguson</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>"</u>
9 AGE in years Last birthday <u>"</u> yrs		10 IF UNDER 1 YEAR Months <u>"</u> Days <u>"</u> Hours <u>"</u> Min <u>"</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <u>H. L.</u>	
11 BIRTHPLACE (County & State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>W. L. L. L.</u>		14 MOTHER'S MAIDEN NAME <u>"</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16 SOCIAL SECURITY NO. <u>247-52-8175</u>	
17 INFORMANT <u>"</u>		Address <u>"</u>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory depression</u> DUE TO <u>"</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Intoxication</u> DUE TO <u>"</u> (c) <u>Unconsciousness</u>			INTERVAL BETWEEN ONSET AND DEATH <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>"</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>May 17, 1958</u> to <u>Sept. 13, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept. 11, 1966</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Robert T. Thigpen</u>		22b DATE SIGNED <u>Sept 13, 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>Robert T. Thigpen</u>		22d ADDRESS <u>None</u>	
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE THEREOF <u>9/16/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>"</u>	23d LOCATION (City or Town) (County) (State) <u>"</u>
24 FUNERAL DIRECTOR <u>"</u>		25a REC'D BY REGISTRAR DATE <u>SEP 14, 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

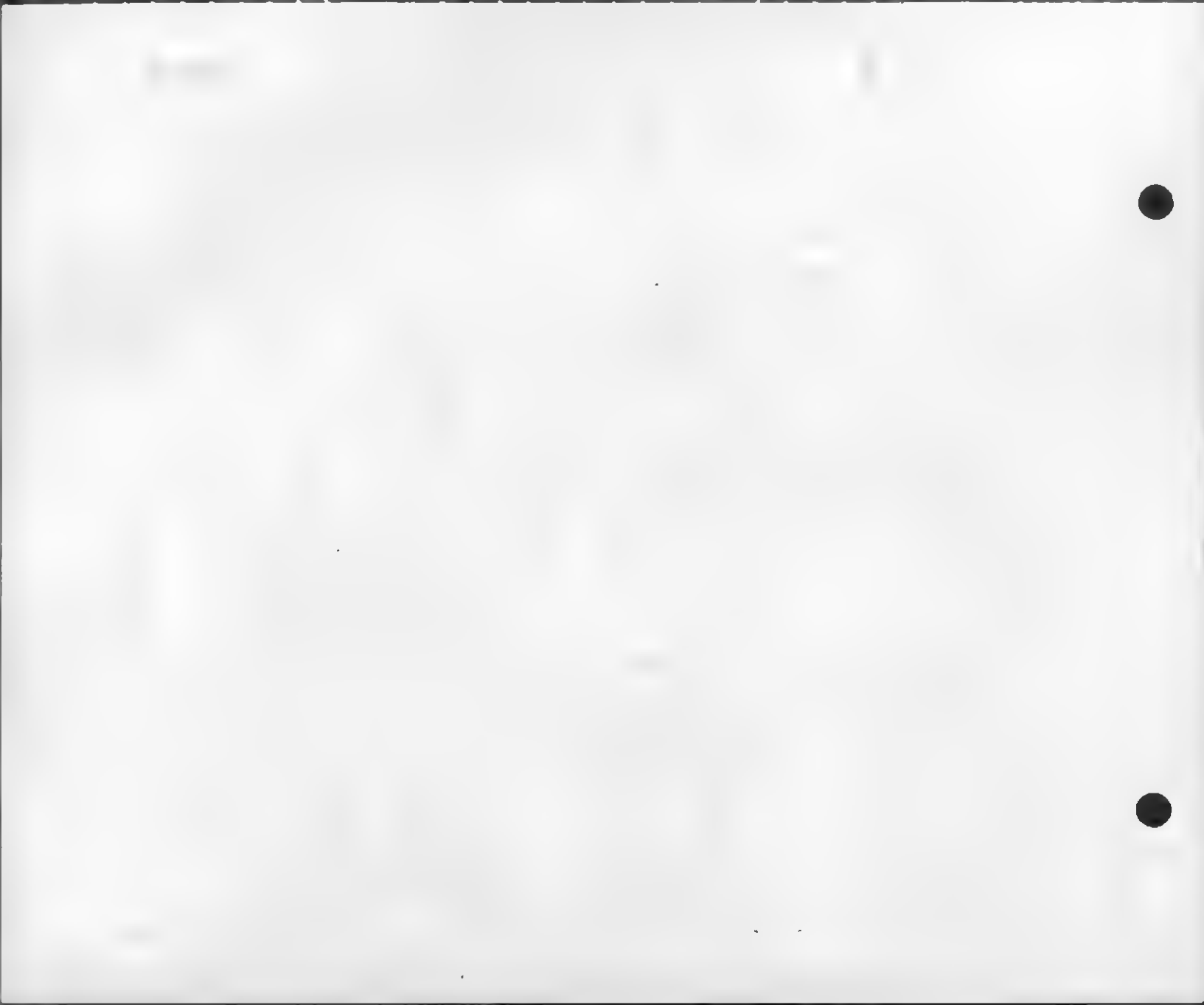
CERTIFICATE OF DEATH

12910

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b Silver Spring	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 215 Crestmoor Circle		d STREET ADDRESS 215 Crestmoor Circle	
3 NAME OF DECEASED (Type or print) Joseph Clements First Middle Last		4 DATE OF DEATH Sept. 16th 1966 Month Day Year	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 11, 1932
10a SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Towa	
13 FATHER'S NAME Joseph Clements		14 MOTHER'S MAIDEN NAME Grace Reade	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs Lyron A. Barnes said she was one		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Rheumatic Heart Disease Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days, 80 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from May , 1962, to 9-16 , 1966, that (I) (we) last saw the deceased alive on 9-15 , 1966, and that death occurred at 2 P M, from causes on and on the date stated above			
22a SIGNATURE Joseph A. Barker M.D.		22b DATE SIGNED 9-16-66	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS Class. Clinic, Wash. DC	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF 9.17.66	23c NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d LOCATION (City or Town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR Lee Funeral Home 300.4th st N.E. Wash.		25a REC'D BY REGISTRAR SEP 13 1966	
25b REGISTRAR'S SIGNATURE J. W. S. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN b <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14005 Cove Lane, Apt. # 104</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>14005 Cove Lane Apt. # 104</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace Bristol Fletcher</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1900</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William M. Rollow</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette Childs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Paul R. Fletcher</u>		Address <u>14005 Cove Lane Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Cervix</u> DUE TO (b) <u>e metastasis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/10/66</u> to <u>9/23/66</u> , that (I) (we) last saw the deceased alive on <u>9/23/66</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E. Stuart Lyddane</u>		22b. DATE SIGNED <u>9/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane, M.D.</u>		22d. ADDRESS <u>3066 2 Street, N.W. Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE <u>SEP 26 1966</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12912

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>D.C.</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c LENGTH OF STAY IN 'b <u>386 - 387</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>				d STREET ADDRESS <u>4910 Connecticut Ave. N.W.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Forbes</u>				4 DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1966</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-17-97</u>	9 AGE 'n years (last birthday) <u>68</u> yrs	F UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. AIR FORCE</u>		11 BIRTHPLACE (Country & State or foreign country) <u>Clark, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3 FATHER'S NAME <u>George H. Forbes</u>				14 MOTHER'S MAIDEN NAME <u>Virginia Hines</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		6 SOCIAL SECURITY NO <u>577-03-7533</u>		17 INFORMANT <u>Wife</u> Address			
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, severe</u> DUE TO (b) <u>Coronary artery insufficiency, mod.</u> (c) <u>Coronary arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>11 yrs</u> <u>11 yrs +</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that (I) (hus/hospital) attended the deceased from <u>Sept 25, 1966</u> , to <u>Sept 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 24 1966</u> , and that death occurred at <u>3:30 A.M.</u> from causes and on the date stated above.							
22a SIGNATURE <u>Stewart Clapp</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 25 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>				22d ADDRESS <u>4740 Chevy Chase Dr. N.W.</u>			
23a BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>Sept. 26, 1966</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24 FUNERAL DIRECTOR (Type) <u>James E. Rogers Jr.</u>				25a REC'D BY REGISTRAR DATE <u>SEP 23 1966</u>		25b REGISTRAR'S SIGNATURE <u>William D. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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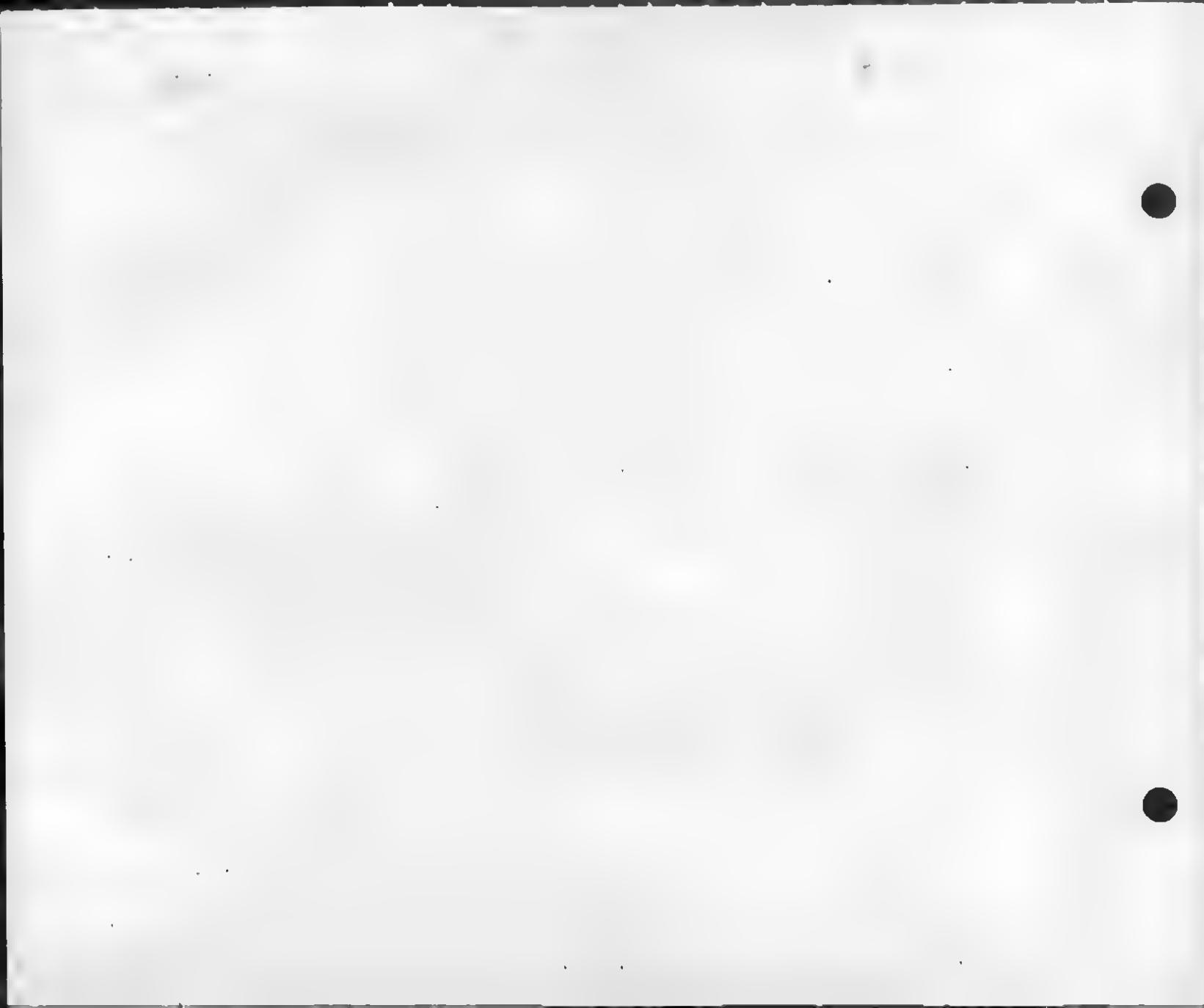
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12913

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY in 1b <u>15 days</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>		c CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Washington Sanitarium and Hospital</u>				d STREET ADDRESS <u>4610 Asbury Avenue</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mrs. Mildred Lee Ford</u>				4 DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1966</u>			
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>October 7, 1981</u>		9 AGE in years last birthday <u>84</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u> </u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mr. Howard Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Bolden</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>215-56-6268</u>		17 INFORMANT <u>Patient's chart</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u> </u> (Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.) (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, Tuberculosis</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12 Sep, 1966</u> to <u>28 Sep, 1966</u> that (I) (we) last saw the deceased alive on <u>27 Sep 1966</u> and that death occurred at <u>12 AM</u> from causes and on the date stated above.							
22a SIGNATURE <u>Thomas P. Fogarty</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>28 Sep 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty</u>		22d. ADDRESS <u>Takoma, Park Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>10/1/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 28 1966</u>		25b REGISTRAR'S SIGNATURE <u> </u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. It should be filed with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

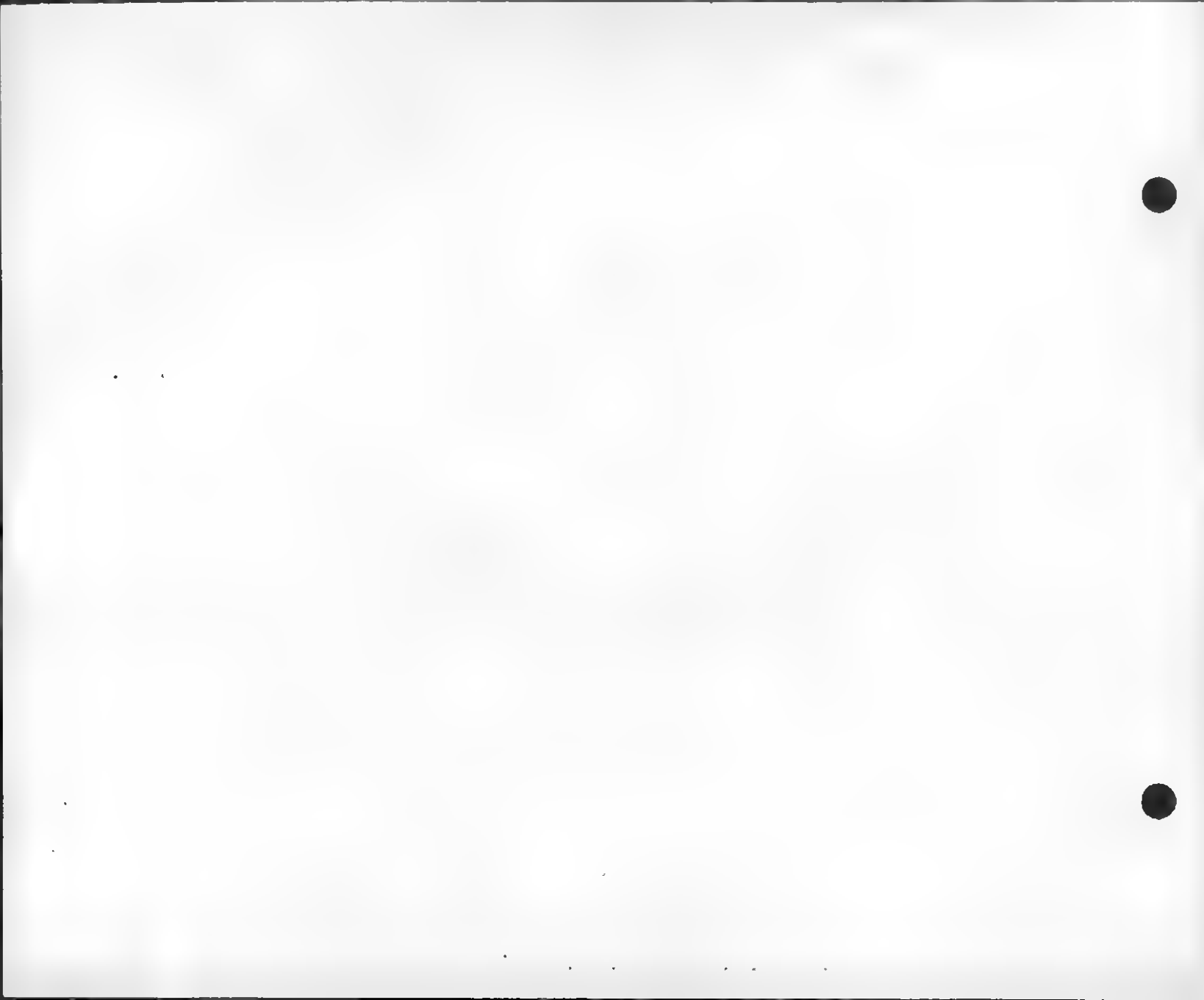
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6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12914

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		2 USUAL RESIDENCE (Where deceased lived if resident. Re-declare before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3 NAME OF DECEASED (Type or print) Effie May Forristall		4 DATE OF DEATH Month 9 Day 28 Year 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-18-1872
9 AGE in years last birthday 94		10 IF UNDER 1 YEAR Month 1 Days 10	
11 IF UNDER 24 HRS Hour 11 M 00		12 TYPE OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry Fitts		14 MOTHER'S MARRIAGE NAME Emma Marden	
15 WAS DISEASE EVER NOTICED BEFORE? (Yes, no, or unknown) (If yes give year or dates of service) no		16 TO A SECURITY NO no	
17 INFORMANT Hospital Admission Record		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for a) (b) and (c) PART I DEATH WAS CAUSED BY 4.2.0 IMMEDIATE CAUSE (a) Acute myocardial insufficiency; DUE TO (b) Arteriosclerotic heart disease DUE TO (c) None Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause most			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND TION GIVEN IN PART I None			
19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour o.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 9-28-66			
ACTUAL SIGNATURE Belden R. Reap, M.D.		22 DATE SIGNED 9-29-1966	
EXAMINER'S NAME (Type) Belden R. Reap, M.D.		Address (Street city town or county) Wheaton, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 10-1-1966	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (City or Town) (County) (State) Suitland, Md.
24 FUNERAL DIRECTOR Joseph J. Gailer's Sons, Inc.		25a REC'D BY REGISTRAR DATE OCT 2 1966	
25b REGISTRAR'S SIGNATURE Wanda Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

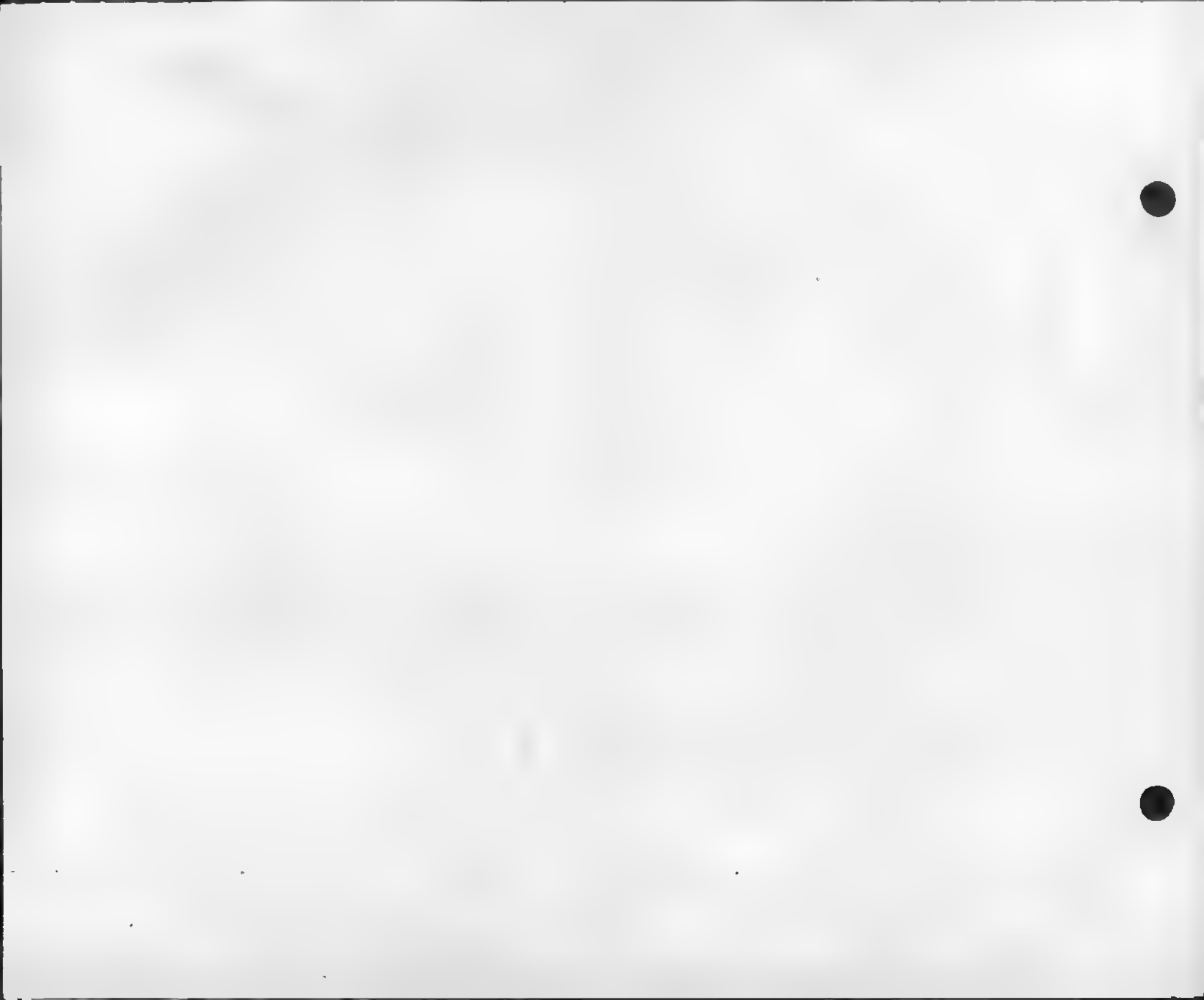
CERTIFICATE OF DEATH

12915

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a STATE <u>Washington D.C.</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>29 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium and Hospital</u>		d STREET ADDRESS <u>1701 Park Road., N.W. Apt. 12</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Charles R Eric Foye</u>		4 DATE OF DEATH Month Day Year <u>September 3 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-2-91</u>
9 AGE (In years last birthday) <u>74 yrs</u>		10 UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Salesman</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Isle Island</u>		12 CITIZEN OF WHAT COUNTRY? <u>American</u>	
13 FATHER'S NAME <u>Charles Foye</u>		14 MOTHER'S MAIDEN NAME <u>Ella Hall</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>310-55-30</u>	
17 INFORMANT <u>patient's chart</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>8-2-66</u> , 19 <u>66</u> , to <u>9-3-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-2-66</u> , 19 <u>66</u> , and that death occurred at <u>11:14</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Stuart L. Nelson</u>		22b DATE SIGNED <u>9-5-66</u>	
22c PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22d ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b DATE THEREOF <u>9/8/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Charles Judge</u>		25a REC'D BY REGISTRAR DATE <u>SEP 3 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12916											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN TB <u>20 years</u>						d. STREET ADDRESS <u>615 Silver Spring Avenue</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>615 Silver Spring Avenue</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carl (NMO) Frey</u>						4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>Male</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH Month <u>Dec.</u> Day <u>2</u> Year <u>1882</u>					
9. AGE (in years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours M. n. <u>83</u> yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired sculptor</u>					
10b. KIND OF BUSINESS OR INDUSTRY <u>Art</u>						11. BIRTHPLACE County & State or foreign country <u>Germany</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>						13. FATHER'S NAME <u>George Frey</u>					
14. MOTHER'S MAIDEN NAME <u>Cecelia Stegner</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>578-12-1757</u>						17. INFORMANT <u>Mrs. Marie Frey</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic myeloid leukemia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Interval between onset and death 2 yrs</u> (c) <u>Interval between onset and death 2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1954</u> to <u>30 Sept 1966</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>23 Sept 1966</u> , and that death occurred <u>5 Sept 1966</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William D. And</u>						22b. DATE SIGNED <u>9/30/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>						22d. ADDRESS <u>9006 Collesville Rd., S. S., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>Oct. 3, 1966</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Prince Georges co., Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>						25. REC'D BY REGISTRAR <u>DATE OCT 1 1966</u>					
25b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>						25c. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

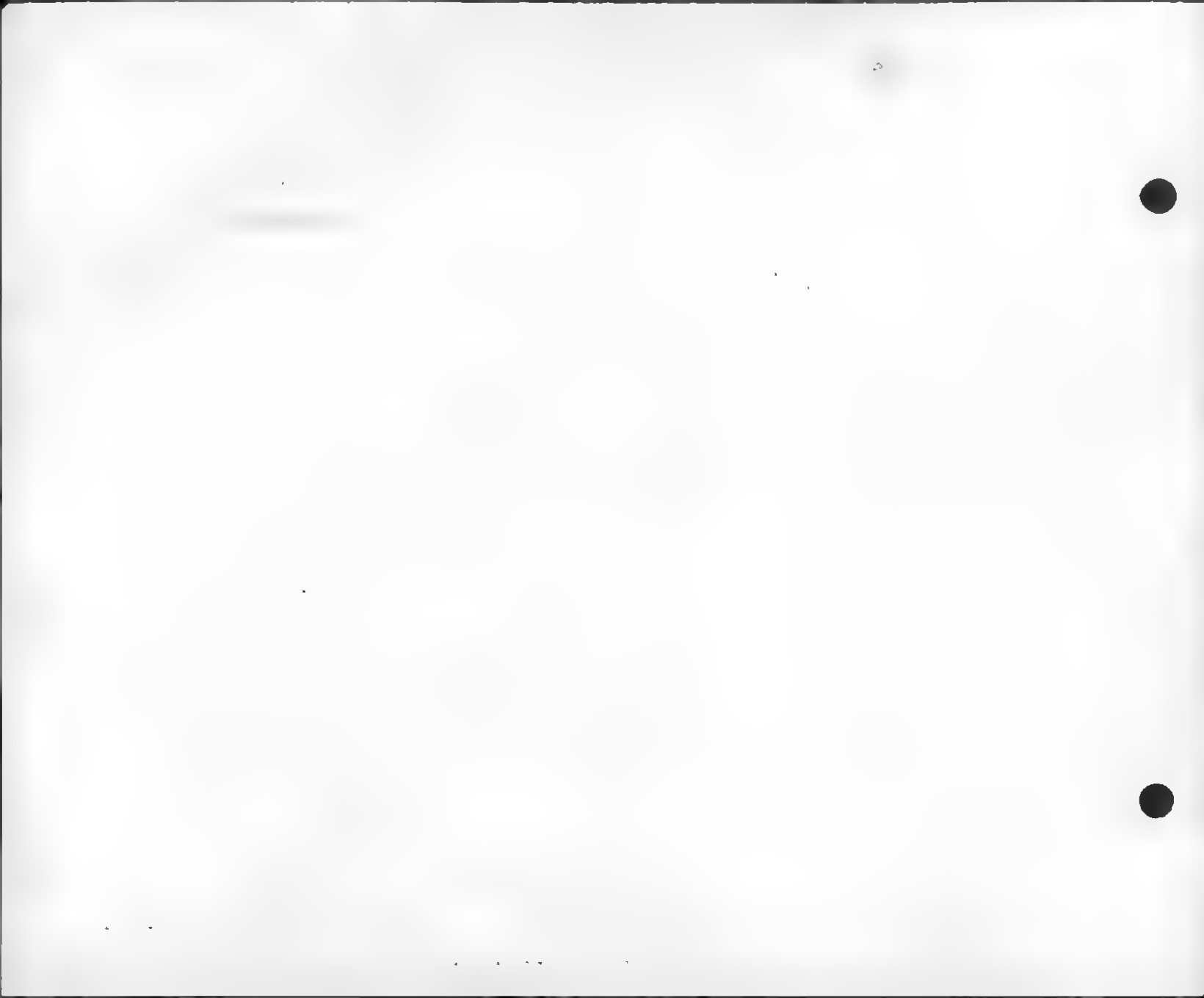
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1291

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN <u>Bethesda</u> c LENGTH OF STAY IN b <u>6 days</u>		2 USUAL RESIDENCE (Where deceased lived if not in a residence before death) a STATE <u>D.C.</u> b CITY OR TOWN <u>Washington</u> c CITY OR TOWN if outside corporate limits, write RURAL and give nearest town	
3 NAME OF DECEASED (Type or print) <u>Agnes O. Fugitt</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/7/1872</u>
9 AGE in years <u>93</u>		10 IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11 IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
12 ALIEN? (If kind of work done during last year, give kind of work done) <u>HOUSEWIFE</u>		13 FATHER'S NAME <u>Geoffrey Wink</u>	
14 MOTHER'S MAIDEN NAME <u>Henrietta Goodrich</u>		15 SOCIAL SECURITY NO. <u>579-14-0364</u>	
16 INFORMANT <u>Mrs E Fugitt</u>		17 ADDRESS <u>daughter in law</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute + Chronic Sudden</u> DUE TO (b) <u>Coronary Vascular Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>			
19 INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
20 PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Left Hip</u>			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <u>Fall at home causing fracture of left hip</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall at home causing fracture of left hip</u>	
20c TIME OF INJURY Month Day Year <u>9:30 pm 9/16 1966</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>	20f (City or town) (County) (State) <u>Washington D.C.</u>
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22 ACTUAL SIGNATURE <u>John S. Ball</u>		23 CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
24 EXAMINER'S NAME (Type) <u>John S. Ball</u>		25 ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
26 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		27 ADDRESS (Street, city, town, or county) <u>9/21/66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9/24/1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24 FUNERAL DIRECTOR <u>Chevy Chase Funeral Home, Wash., D.C.</u>		25 REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>	
26 REGISTRAR'S SIGNATURE <u>[Signature]</u>		27 REGISTRAR'S SIGNATURE <u>[Signature]</u>	

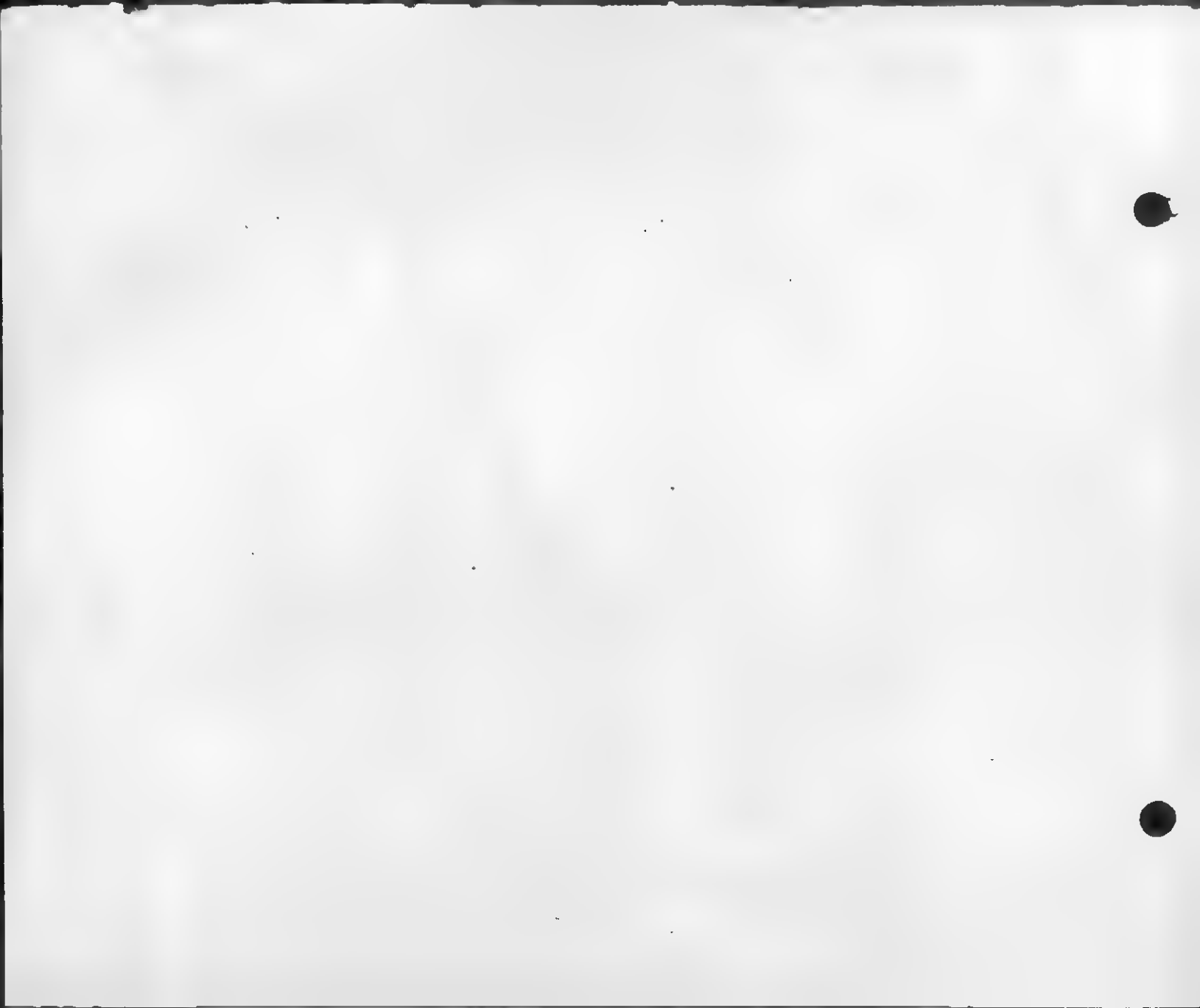


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12918											
1. PLACE OF DEATH a. COUNTY <u>WILMINGTON</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WILMINGTON</u> b. COUNTY <u>NEW CASTLE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY in 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILMINGTON</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HEALTH CARE CENTER</u>						d. STREET ADDRESS <u>1100 N. 1st St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH Month Day Year			19 <u>66</u>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>N. Vaughn - Item #2</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Heart Condition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>Coronary Artery Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hr</u> <u>3.1 hr</u> <u>12 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>66</u> to <u>9/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/10/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>BURIAL</u>		<u>9-11-66</u>		<u>Sandy Spring</u>		<u>SANDYSPRING, Md.</u>					
24. FUNERAL DIRECTOR <u>R. L. Snowden, Rockville, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

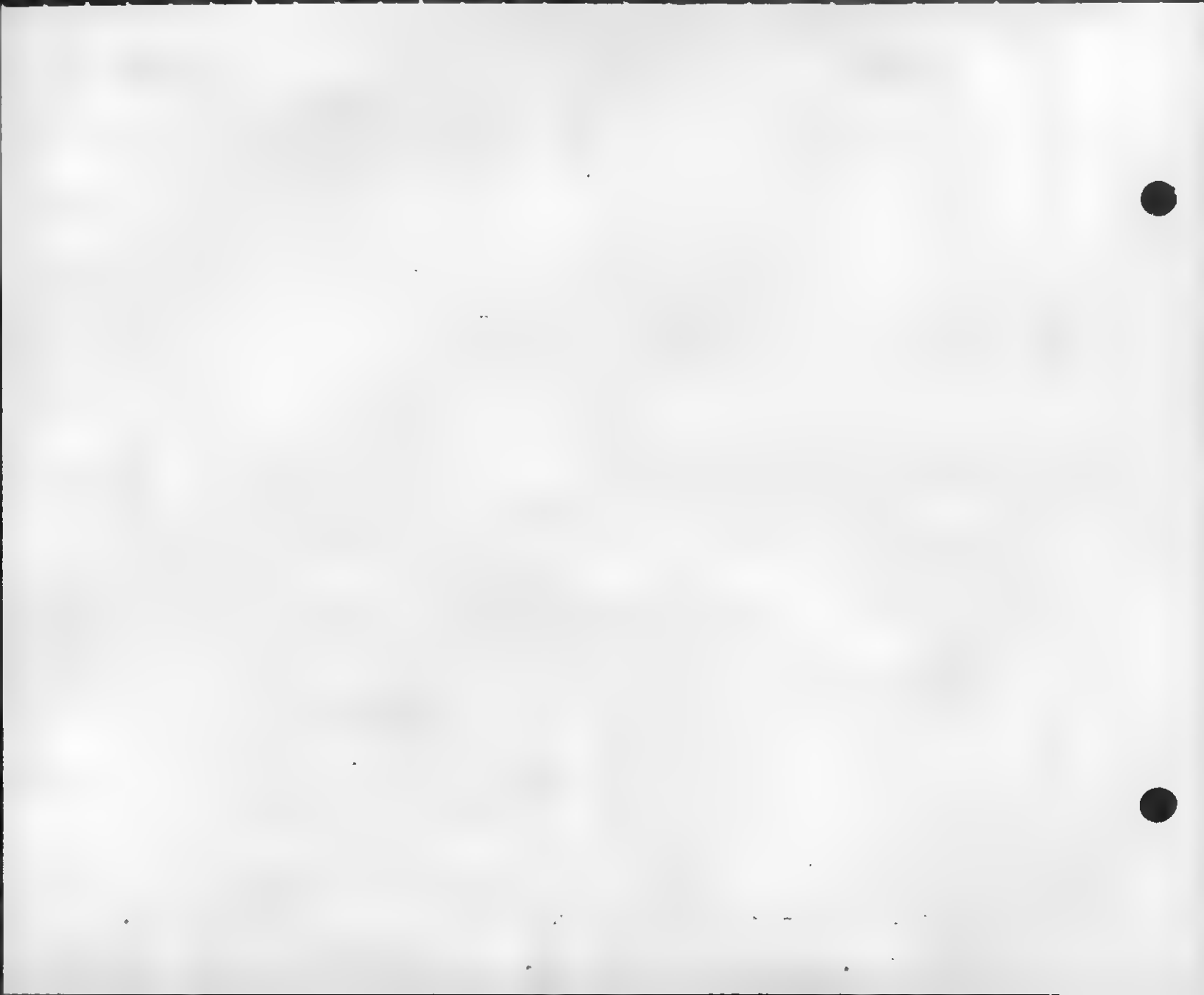
CERTIFICATE OF DEATH

12919

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c LENGTH OF STAY IN b 13 DAYS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSPITAL		d STREET ADDRESS BENTLEY ROAD	e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First HANNAH Middle BALL Last GILPIN		4 DATE OF DEATH Month 9 Day 9 Year 19 66	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-11-98
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months Days 	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY 	11 BIRTHPLACE (County & State, or foreign country) ENGLAND
12 CITIZEN OF WHAT COUNTRY? England		13 FATHER'S NAME WALTER BALL	
14 MOTHER'S MAIDEN NAME HANNAH BENNETT		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 		17 INFORMANT Address MEDICAL RECORDS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO 16 x 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 66 , to 9/9 , 19 66 , that (I) (we) last saw the deceased alive on 9/8 , 19 66 , and that death occurred at 8:15 A.M. from causes and on the date stated above.			
22a SIGNATURE A. D. Bonifant		22b DATE SIGNED 9-9-66	
22c PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-12-66	23c NAME OF CEMETERY OR CREMATORY Friends	23d LOCATION (City or Town) (County) (State) Sandy Spring, Md.
24 FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a REC'D BY REGISTRAR SEP 13 1966 25b REGISTRAR'S SIGNATURE Charles Judge	

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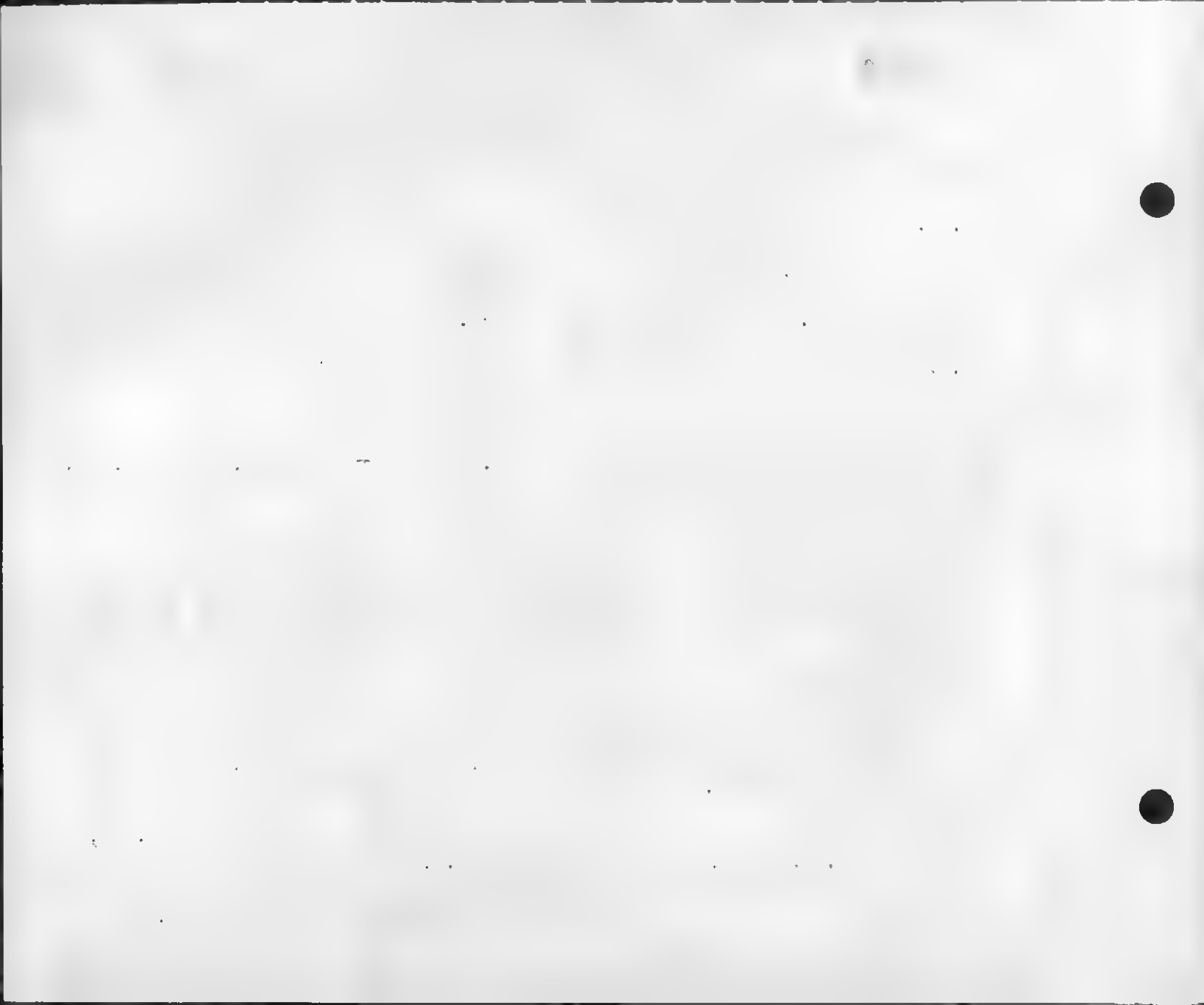
1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12920

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia b. COUNTY Prince William	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U. S. Naval Hospital, Bethesda, Maryland		e. STREET ADDRESS Box 152	
3. NAME OF DECEASED (Type or print) First John Lorenz Middle GLENN Last GLENN		4. DATE OF DEATH Month September Day 9 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1906
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Stanton, Virginia		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME William Glenn		15. MOTHER'S MAIDEN NAME Elizabeth Pratt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO 223 38 2297	
18. INFORMANT Mrs. Jean Glenn, Box 152, Triangle, Va.		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Artery Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 19.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Aug. 11 , 19 66 , to Sept. 9 , 19 66 , that (we) last saw the deceased alive on Sept. 9 , 19 66 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>J. E. Davis</i>		22b. DATE SIGNED Sept. 10, 1966	
22c. PHYSICIAN'S NAME (Type) J. E. DAVIS, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.	
23d. LOCATION (City or town) (County) (State)		23e. RECORD BY REGISTRAR DATE SEP 14 1966	
23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		23g. REGISTRAR'S NAME Charles Judge	
24. FUNERAL DIRECTOR Cunningham Mountcastle Funeral Home, Woodbridge Virginia		ADDRESS	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Tie pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 7/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

1 PLACE OF DEATH a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY c. LENGTH OF STAY IN IS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IF RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		4 DATE OF DEATH	
5 SEX 6 RACE OR PACE 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH 9 AGE (If year of birthday) 10 IS DECEASED EMPLOYED (If yes, give work done during last 7 days) 11 FATHER'S NAME		12 MONTH 13 DAY 14 YEAR 15 AGE (If year of birthday) 16 UNDER 1 YEAR 17 UNDER 24 HRS 18 COUNTRY OF WHAT COUNTRY?	
10a IS DECEASED EMPLOYED (If yes, give work done during last 7 days) 11 FATHER'S NAME		10b KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16 SOCIAL SECURITY NO 17 INFORMANT 18 ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 INTERVAL BETWEEN ONSET AND DEATH 20c EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 20d DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
23a BURIAL CREMATION, REMOVAL (Specify) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State)		25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE	

24 FUNERAL DIRECTOR
John B. Thomas
Warner E. Humphrey, Inc.
25a REC'D BY REGISTRAR
OCT 5 1966
25b REGISTRAR'S SIGNATURE
J. W. Judge



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent prior to burial, cremation, or removal and in any event within 72 hours after death.

VR AT5ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12922

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN <u>Grand Rapids</u> c. RURAL OR SUBURBAN <u>Grand Rapids</u> d. NAME OF HOSPITAL OR INSTITUTION <u>Grand Rapids Hospital</u>		2 USUAL RESIDENCE (Where deceased lived for at least 10 days prior to death) a. STATE <u>MI</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN <u>Grand Rapids</u> d. STREET ADDRESS <u>Grand Rapids</u>	
3 NAME OF DECEASED Type and print <u>William J. Giltis</u>		4 DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-15-15</u>
9 AGE in years <u>51</u> Months <u>5</u> Days <u>11</u>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Minutes <u>0</u>	
11 BIRTHPLACE (State or foreign country) <u>Michigan</u>		12 "GIVEN" OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>William J. Giltis</u>		14 MOTHER'S MAIDEN NAME <u>William J. Giltis</u>	
15 WAS DECEASED EVER IN ARMED FORCES (Army, Navy, Air Force, Marine Corps, Coast Guard, etc.) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16 SOCIAL SECURITY NO. <u>Yes</u>	
17 INFORMANT <u>Michigan</u>		Address <u>Grand Rapids</u>	
18 CAUSE OF DEATH (Enter or give one cause per line for a, b, and c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>lost</u> DUE TO <u>lost</u> DUE TO <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>lost</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lost</u>			
19a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		19b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>lost</u>	
20a TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20b INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>lost</u>	20d (City or town) (County) (State) <u>lost</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Selden R. Reap</u> M.D.		CHIEF MED. CA. EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME Type <u>BELOEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a BIRTHPLACE (State or foreign country) <u>Michigan</u>		22b DATE SIGNED <u>Sept. 1, 1966</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept. 5, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Meigs, Illinois</u>
24 FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>SEP 7 1966</u>	
25b REG. STRAR'S SIGNATURE <u>Charles Judge</u>		25c ADDRESS <u>8434 Georgia Ave. Silver Spring, MD</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

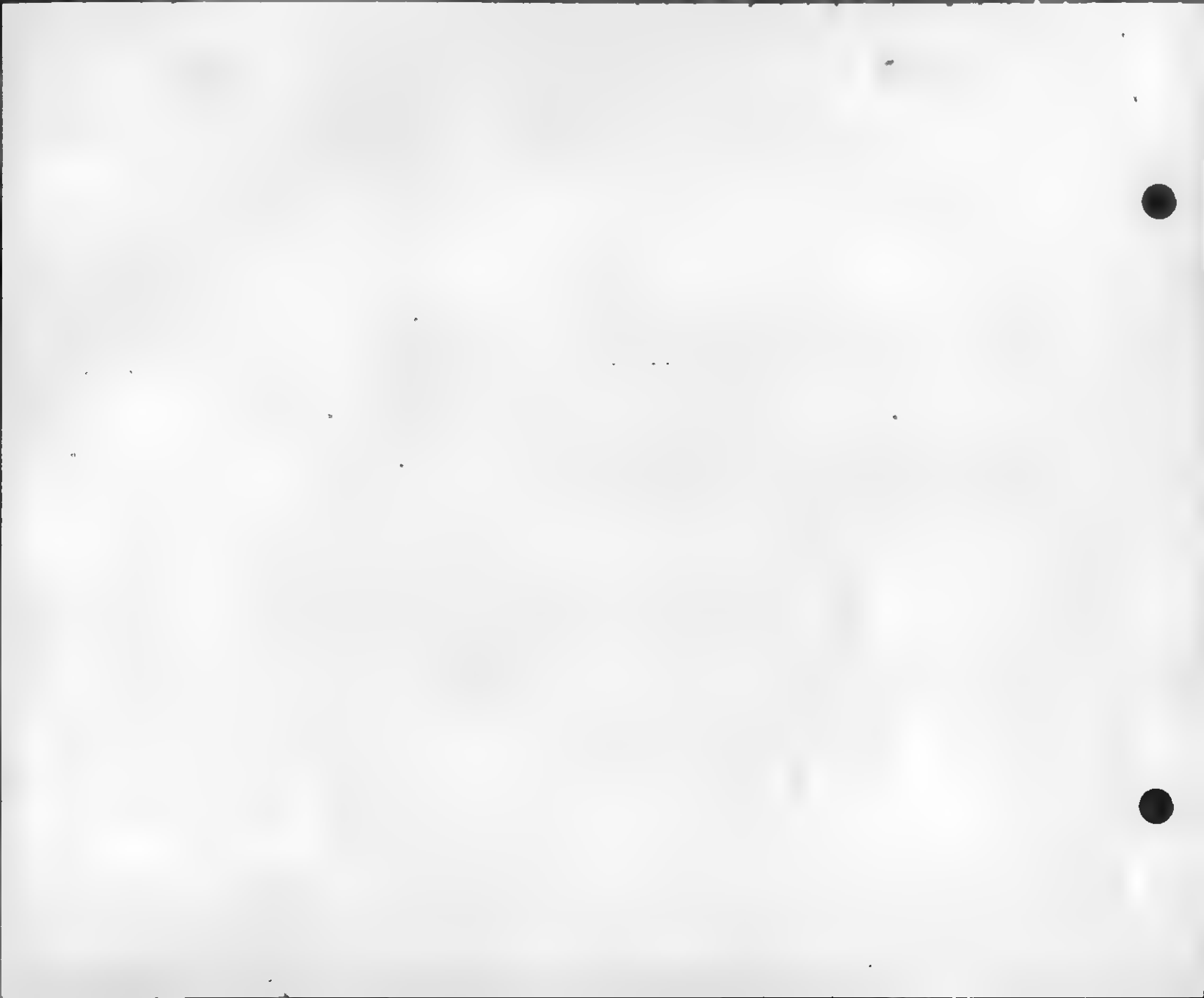
CERTIFICATE OF DEATH

12923

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if first listed residence before admission) a STATE MARYLAND b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN TB 18 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6613 Elgin Lane		e STREET ADDRESS 6613 Elgin Lane	
3 NAME OF DECEASED (Type or print) Mildred Ashley Gould		4 DATE OF DEATH Month September Day 29 Year 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Apr. 18, 1889
9 AGE (In years birth day) 77 yrs		F UNDER 1 YEAR Months 5 Days 11	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) Mass.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME A. Davis Ashley		14 MOTHER'S MAIDEN NAME Carrie L. Morse	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-46-0673	
17 INFORMANT Husband		Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO coronary atherosclerosis Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden death (c) Sudden death			INTERVAL BETWEEN ONSET AND DEATH Sudden death
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1966 , to Sept. 29, 1966 , that (I) (we) last saw the deceased alive on Sept. 9, 1966 and that death occurred at 7:20 P.M. from causes and on the date stated above			
22a SIGNATURE Alban W. Eger M.D.		22b DATE SIGNED 9/29/66	
22c PHYSICIAN'S NAME (Type) Alban W. Eger		22d ADDRESS 1801 Eye St N.W.	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF 10-1-66	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d LOCATION (City or Town) (County) (State) Suitland, Maryland
24 FUNERAL DIRECTOR Robert A. Pumphrey		25a REC'D BY REGISTRAR Bethesda, Maryland	
25b REGISTRAR'S SIGNATURE Charles Justice		DATE OCT 7 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



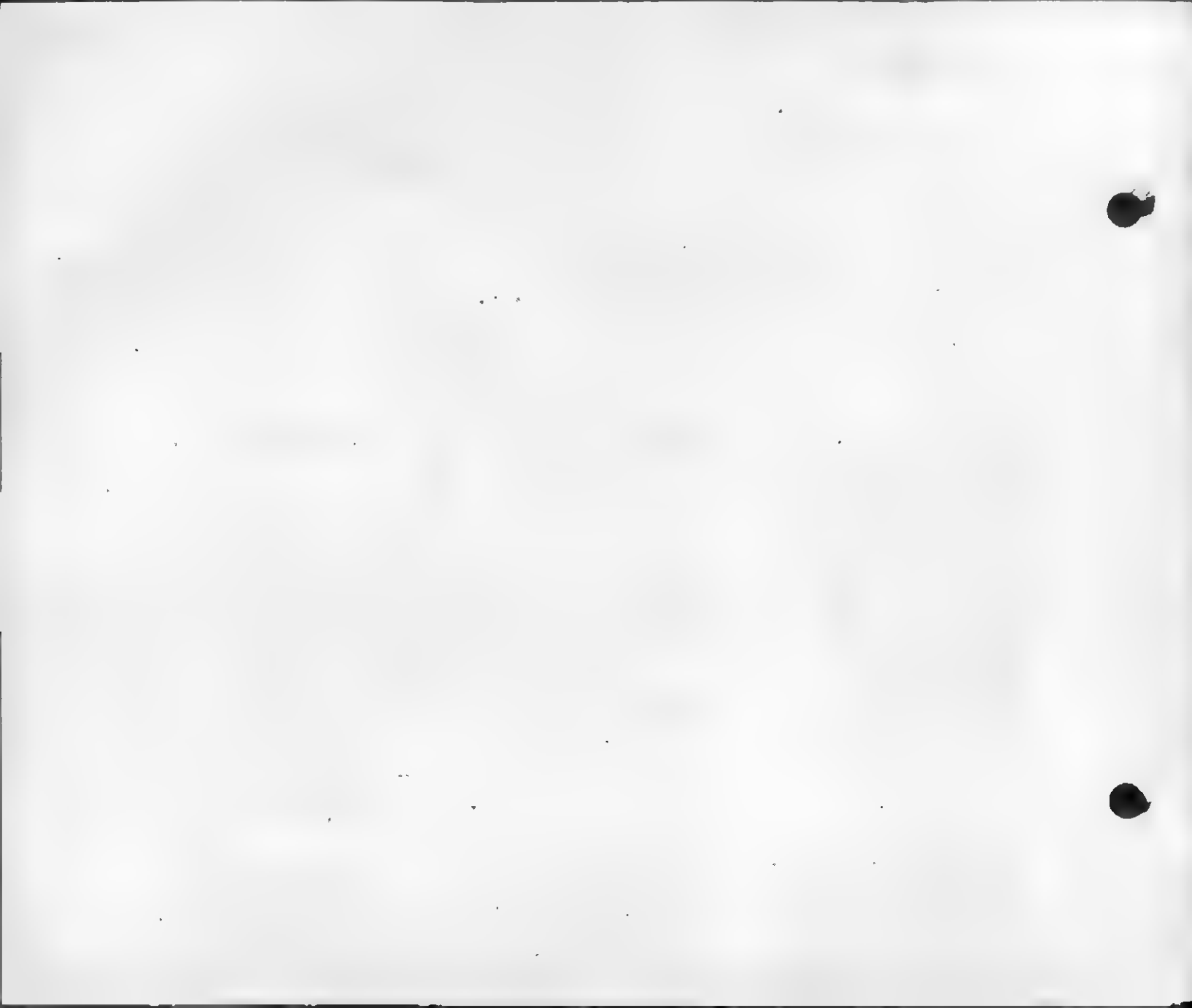
CERTIFICATE OF DEATH

Reg. Dist. No.

12924

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Smith	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville---Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chilhowie	
c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Thomas Franklin Middle Greer Last		4. DATE OF DEATH Month Sept Day 26 Year 19 66	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 7-1890
9 AGE (In years lost birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Riley Greer		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 227-05-1616	
INFORMANT		Address	
Mrs Dora Greer, Poolesville, R.F.D. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH years
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 May , 19 65 , to 26 Sept. , 19 66 , that I last saw the deceased alive on 26 Sept. , 19 66 , and that death occurred at 11:45 A.M., from the causes and on the date stated above			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 26 Sept 66	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/66	22c. NAME OF CEMETERY OR CREMATORY Macedonia Church	22d. LOCATION (City, town or county) (State) Chilhowie, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE William B. Wilson		ADDRESS Barnesville, Md	24a. REC'D BY REGISTRAR DATE
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

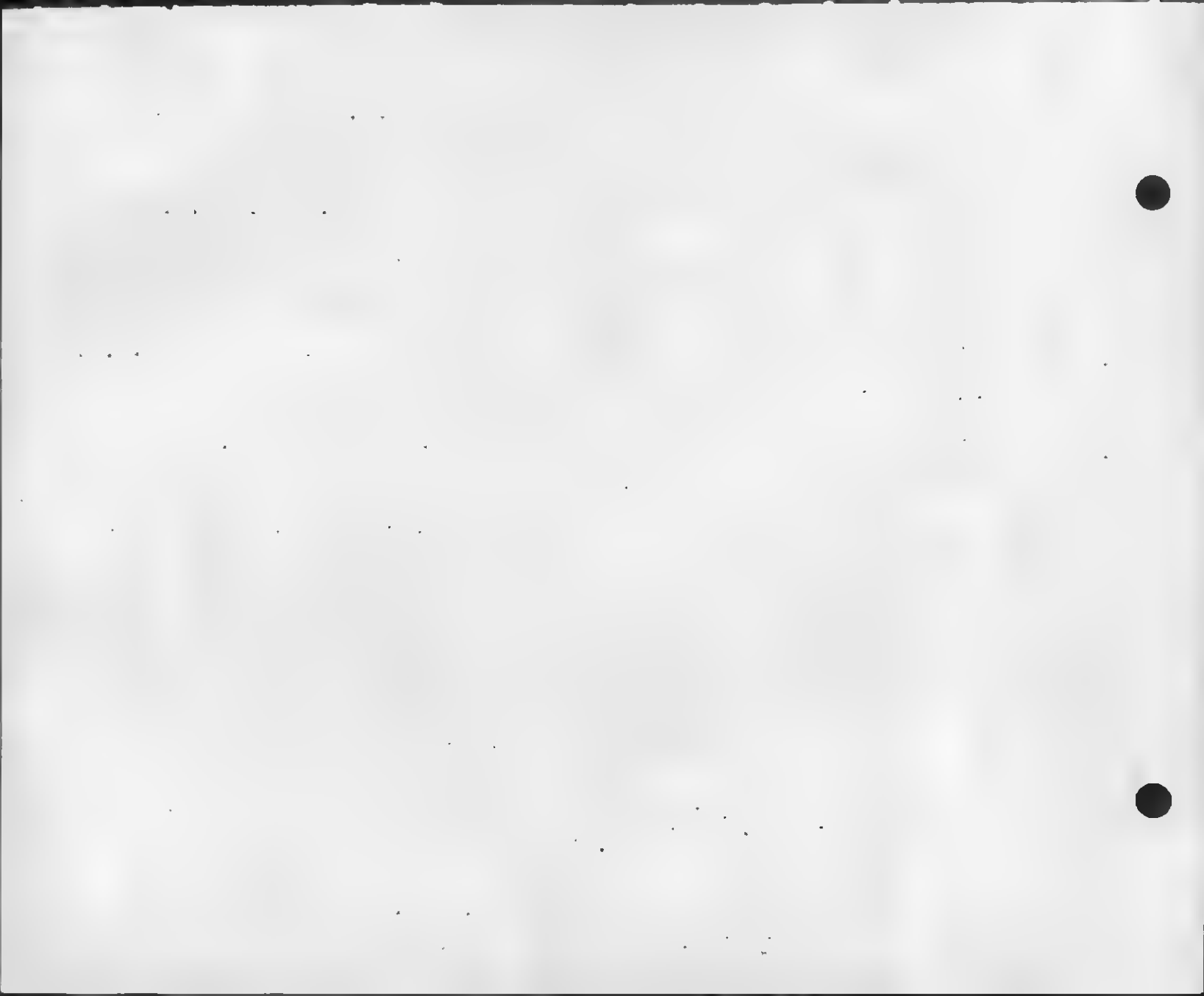


12925

MEDICAL CERTIFICATION

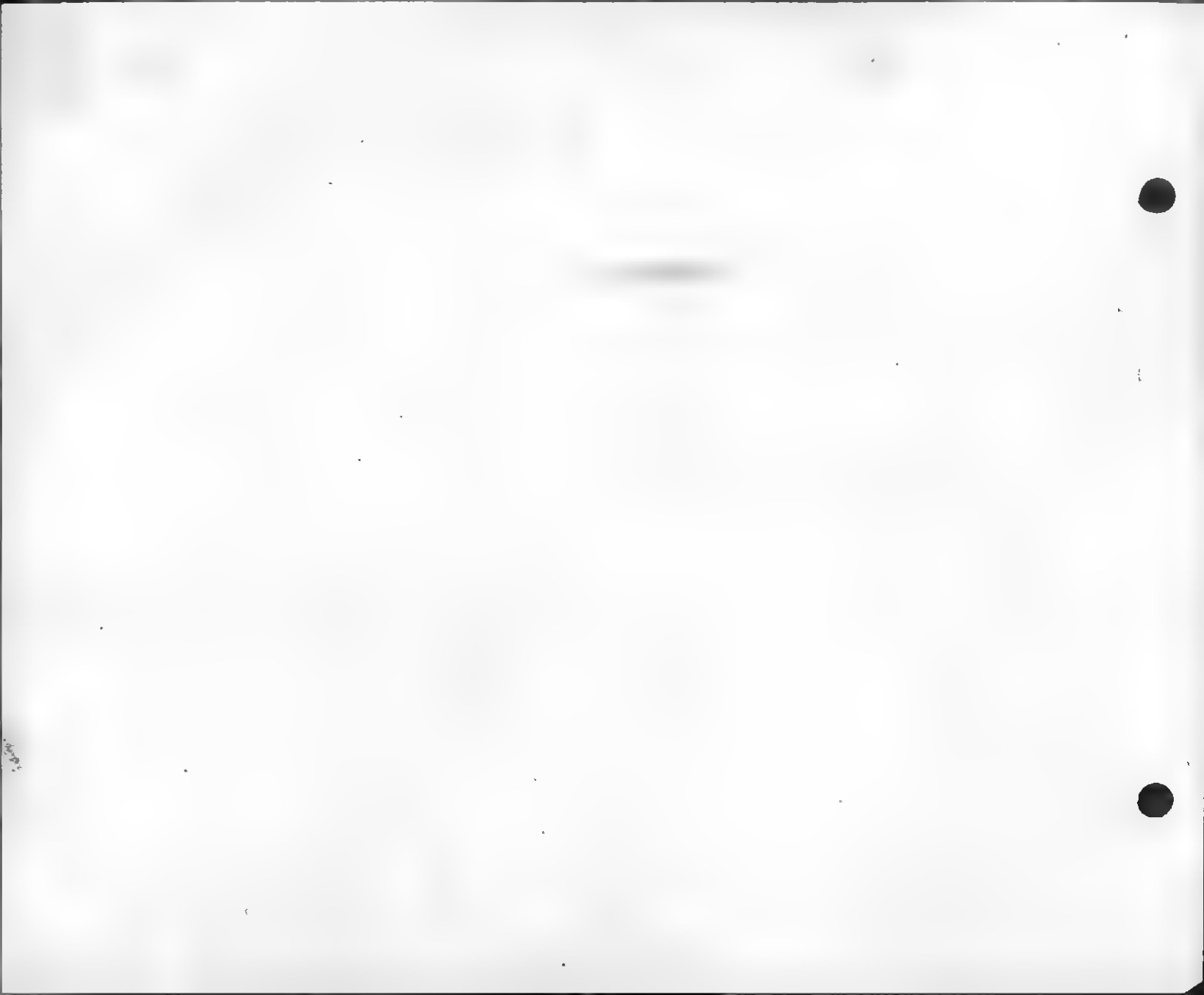
VR 215 (4)
ZDM 65

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Filia ¹ and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death

VR A15ME (5)
6M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12927

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN <u>BETHESDA</u> <u>MARYLAND</u> c. LENGTH OF STAY "IN" <u>21 hrs 25 min</u> d. NAME OF HOSPITAL OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE Where deceased lived, if institution. Residence before admission a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN <u>SANDY SPRING</u> STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WALTER LEROY HALL</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept 17, 1966</u>		9. AGE in years If UNDER 1 YEAR If UNDER 24 HRS. last birthday Months Days Hours Mins <u>21</u> <u>25</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>WALTER LEROY DINES</u>		14. MOTHER'S MAIDEN NAME <u>ELLA LOUISE HALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only in Part I. Do not include conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE <u>Respiratory Distress Syndrome</u> <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter in detail in Part I. Part II. from 5)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town <u>Rockville</u> County <u>MD.</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> <u>1966</u> to <u>9/18</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> <u>1966</u> , and that death occurred at <u>6:40</u> <u>AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Kroll</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1125 ROCKVILLE PIKE, ROCKVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City, town or county, State) <u>Sandy Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. J...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

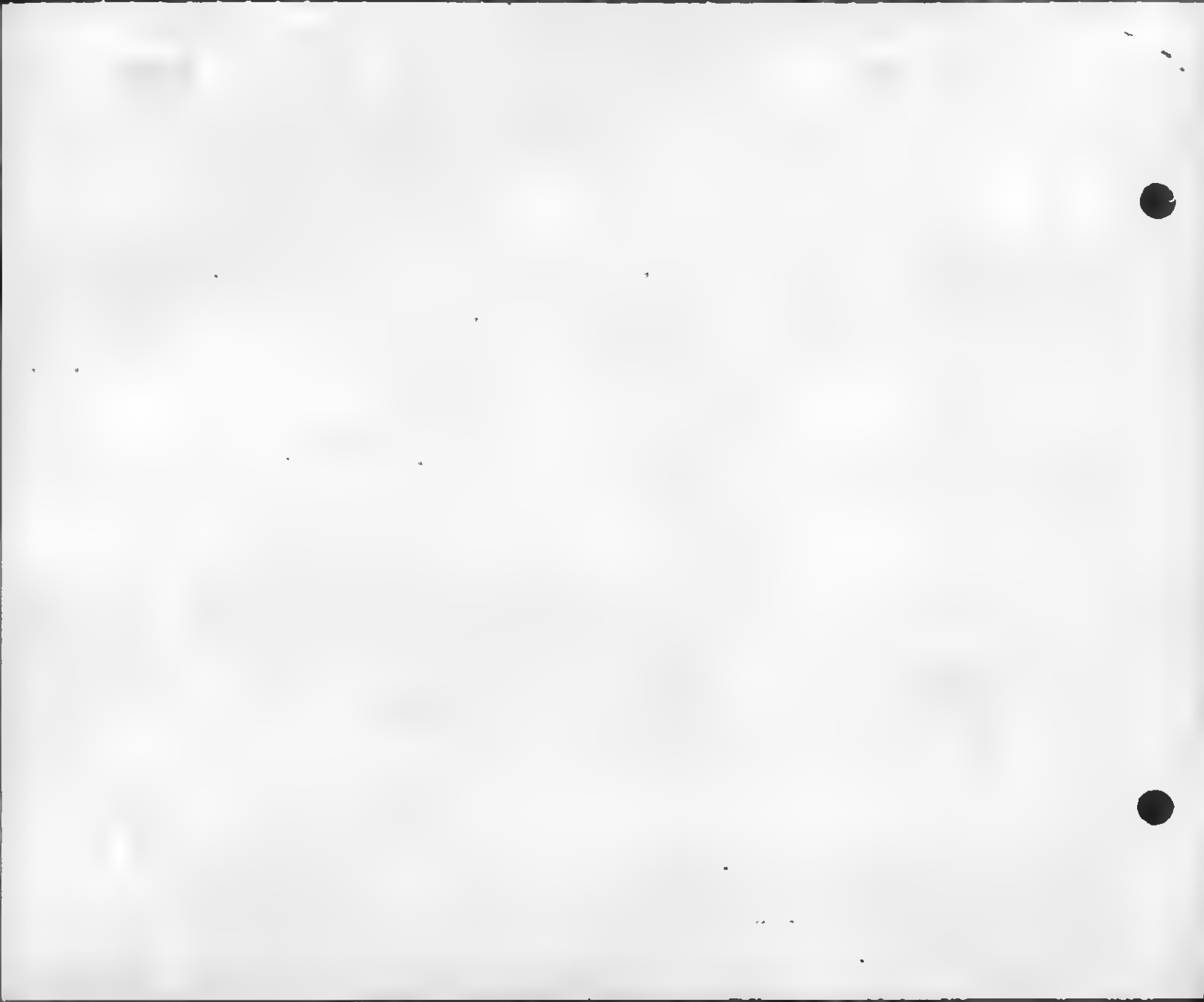
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12928

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5800 Johnson Avenue				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d STREET ADDRESS 5800 Johnson Avenue e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) BEATRICE E. HAMILTON First Middle Last 4 DATE OF DEATH Sept. 6, 19 66 Month Day Year				5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH Oct. 23, 1884 9 AGE in years (a) b (rthday) yrs 81 10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11 BIRTHPLACE (Country & State, or foreign country) Canada 12 CITIZEN OF WHAT COUNTRY? U. S.			
13 FATHER'S NAME Edward Ermatinger				14 MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No				16 SOC. A. SECURITY NO Unknown		17 INFORMANT Husband George T. Hamilton Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL EY ARREST DUE TO (b) EMPHYSEMA AND CORONARY ARTERIO SCLEROSIS DUE TO (c) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 1966 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1966 , to Sept. 6, 1966 , that (I) (we) last saw the deceased alive on Sept. 5, 1966 , and that death occurred at 7:00 A.M. from causes and on the date stated above							
22a SIGNATURE JOSEPH D. CONNOR 22c PHYSICIAN'S NAME (Type)				22b DATE SIGNED Sept. 6, 1966 22d ADDRESS 9420 Old Georgetown Rd. Bethesda, Maryland		22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 9-8-66		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a REC'D BY REGISTRAR DATE SEP 8 1966		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12929

1 PLACE OF DEATH a COUNTY <u>FOUR MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>D.C.</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c LENGTH OF STAY IN TB	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>		d STREET ADDRESS <u>410 - MARY AVE. N.E.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <u>CARROLL HALL SANITARIUM.</u>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>REGIA</u> Middle <u>R</u> Last <u>HANLEIN</u>		4 DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>5</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 18-1885</u>
9 AGE (In years last birthday) <u>86</u> yrs		10a. SOCIAL OCCUPATION (Give kind of work done during most of working life ever first year) <u>SALES LADY (AT) NEXT STORE</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>HUGHESVILLE MD</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13 FATHER'S NAME <u>JOHN LAMAR</u>	
14 MOTHER'S MAIDEN NAME <u>MARTHA ILE MARR</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT <u>HARRY HANLEIN</u> Address <u>7504 HILTON AVE. TAKOMA PARK</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL HEMORRHAGE</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 6</u> , 19 <u>65</u> , to <u>SEPT 5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 5</u> , 19 <u>66</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>[Signature]</u> M.D.		22b DATE SIGNED <u>SEPT. 5, 1966</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <u>5206 NORWAY DR CHEVY CHASE, MD</u>	
23a BURIAL-CREATION REMOVAL (Specify)	23b DATE THEREOF <u>SEP 15 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>St. Ignace</u>	25a RECD BY REGISTRAR <u>SEP 7 1966</u>	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

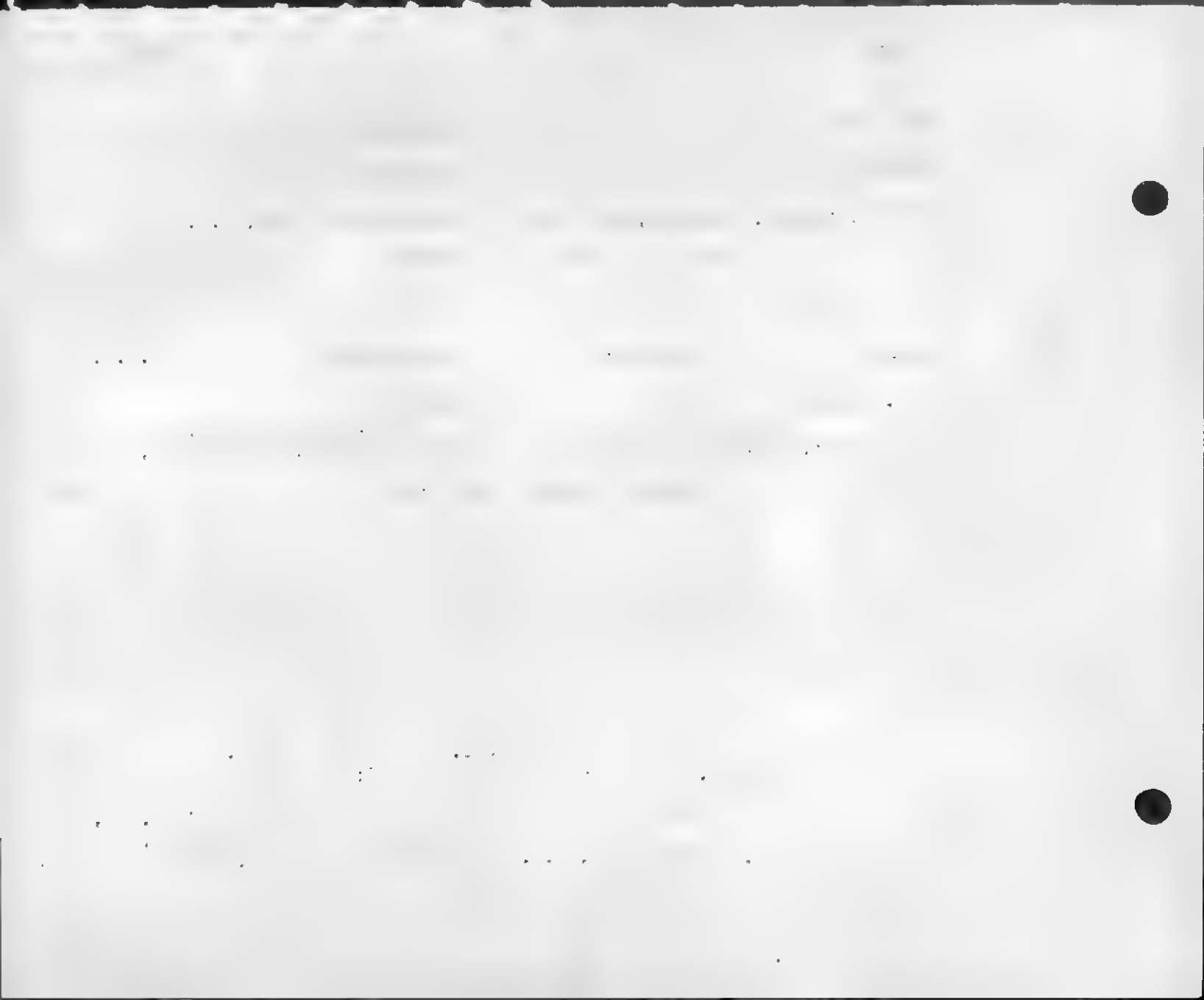


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12930

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
c. LENGTH OF STAY IN B <u>One day</u>		d. STREET ADDRESS <u>5027 Suitland Road, S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clifford Ezra Hanshew</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 July 1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John W. Hanshew</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>234-01-1046</u>	
17. INFORMANT <u>The Medical Records,</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple myeloma 2 years</u> 20a. ACCIDENT WAS UNDERLYING, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 12</u> , 19 <u>66</u> , to <u>Sept. 13</u> 19 <u>66</u> , that <u>XIX</u> (we) last saw the deceased alive on <u>Sept. 13</u> 19 <u>66</u> , and that death occurred at <u>10:35 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman S. Lichtenstein</u>		22b. DATE SIGNED <u>Sept. 13, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman S. Lichtenstein, M.D.</u>		22d. ADDRESS <u>Institutes of Health, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wallace & Wallace Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Clintoville, W Va.</u>
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>4308 Suitland Rd. Suitland, Maryland</u>	

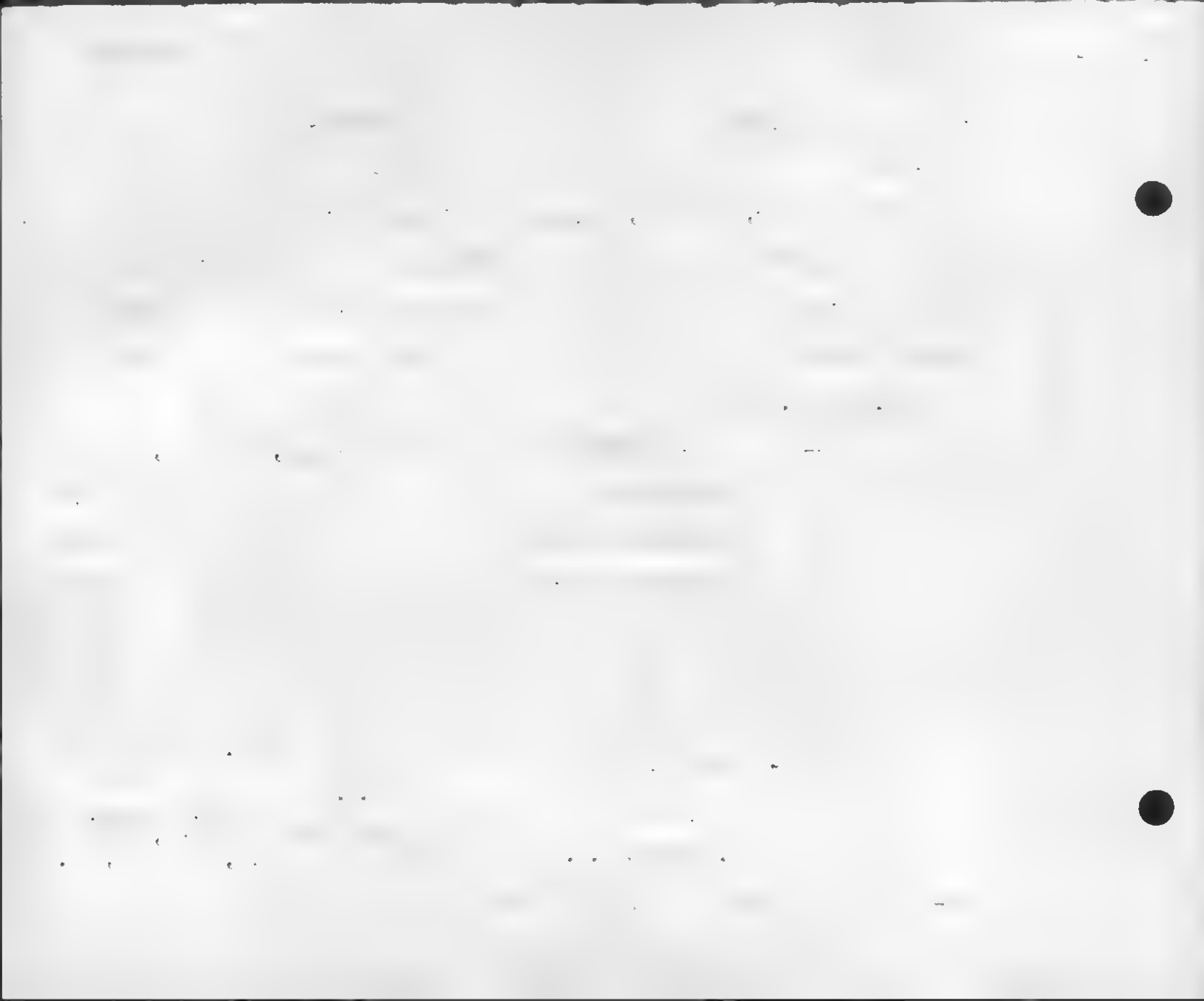


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11-57
12931
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dover</u>		
c. LENGTH OF STAY IN 1b <u>42 Days</u>			d. STREET ADDRESS <u>121 Hazel Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Archie</u> Last <u>Harman</u>			4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>19 66</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>5 September 1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fuel Oil Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Thaddeus S. Harman</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Crites</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-12-1289</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emboli</u> DUE TO (c) <u>Muscular dystrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u> <u>6 years</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 July</u> , 19 <u>66</u> , to <u>1 Sept.</u> , 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 September</u> 19 <u>66</u> , and that death occurred at <u>11:50</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert C. Griggs</u>			22b. DATE SIGNED <u>1 September 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Griggs, M.D.</u>			22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		23b. DATE THEREOF <u>9/2/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Dover, DELAWARE</u>					
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>			25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>		
25b. REGISTRAR'S SIGNATURE <u>SEP 6 1966</u>			25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



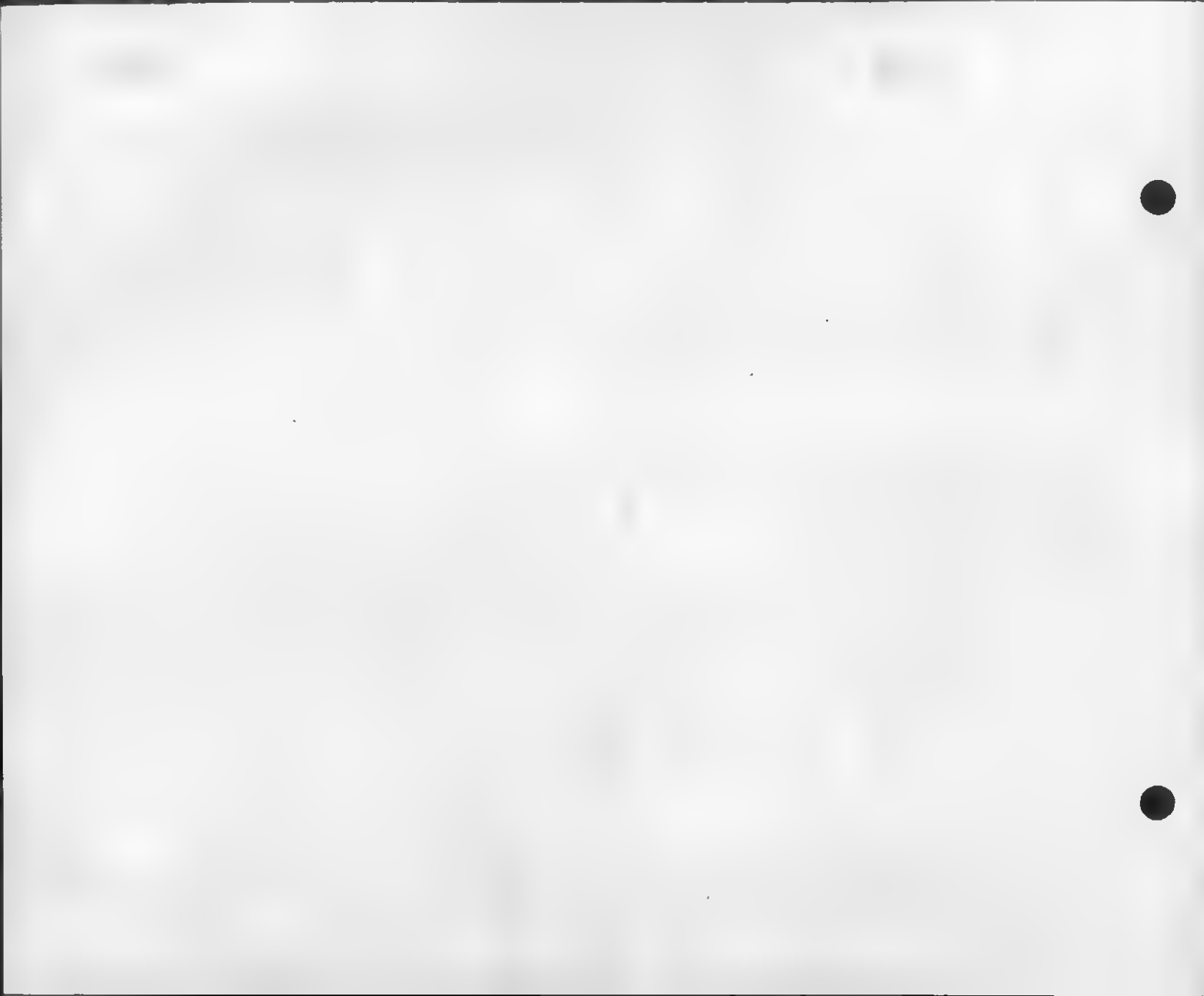
CERTIFICATE OF DEATH

12932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN (b) <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wheaton Hospital</u>				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>11111 1st St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Robert H. Herring</u> First Middle Last 4 DATE OF DEATH <u>11/1/66</u> Month Day Year				5 SEX <u>Male</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>6/1/1911</u> 9 AGE, in years (last birthday) <u>55</u> Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTH PLACE (County & State or foreign country) <u>Wheaton, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles H. Herring</u>				14 MOTHER'S MAIDEN NAME <u>Mrs. E. Herring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, only unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>214-444-4444</u>		17 INFORMANT <u>W. H. Herring</u> Address <u>11403 Rte. 1, Wheaton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of prostate & metastasis</u> DUE TO (b) <u>Paralytic illness</u> DUE TO (c) <u>Probably splenic splenic tumor</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year <u>11/1/66</u> hour a.m. p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21: I certify that (I) (this has to) attended the deceased from <u>11/1/66</u> , to <u>11/1/66</u> , that (I) (we) last saw the deceased alive on <u>10/31/66</u> , and that death occurred at <u>11/1/66</u> M, from causes and on the date stated above.							
22a SIGNATURE <u>W. H. Herring</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b DATE SIGNED <u>11/1/66</u>			
22c PHYSICIAN'S NAME (Type) <u>W. H. Herring</u>				22d ADDRESS <u>11111 1st St.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Wheaton</u>		23b DATE THEREOF <u>11/3/66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Wheaton</u>		23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>W. H. Herring</u> ADDRESS <u>11111 1st St.</u>				25a REC'D BY REGISTRAR <u>SEP 5 1966</u> DATE		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

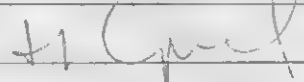
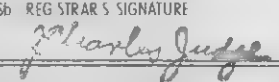


MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

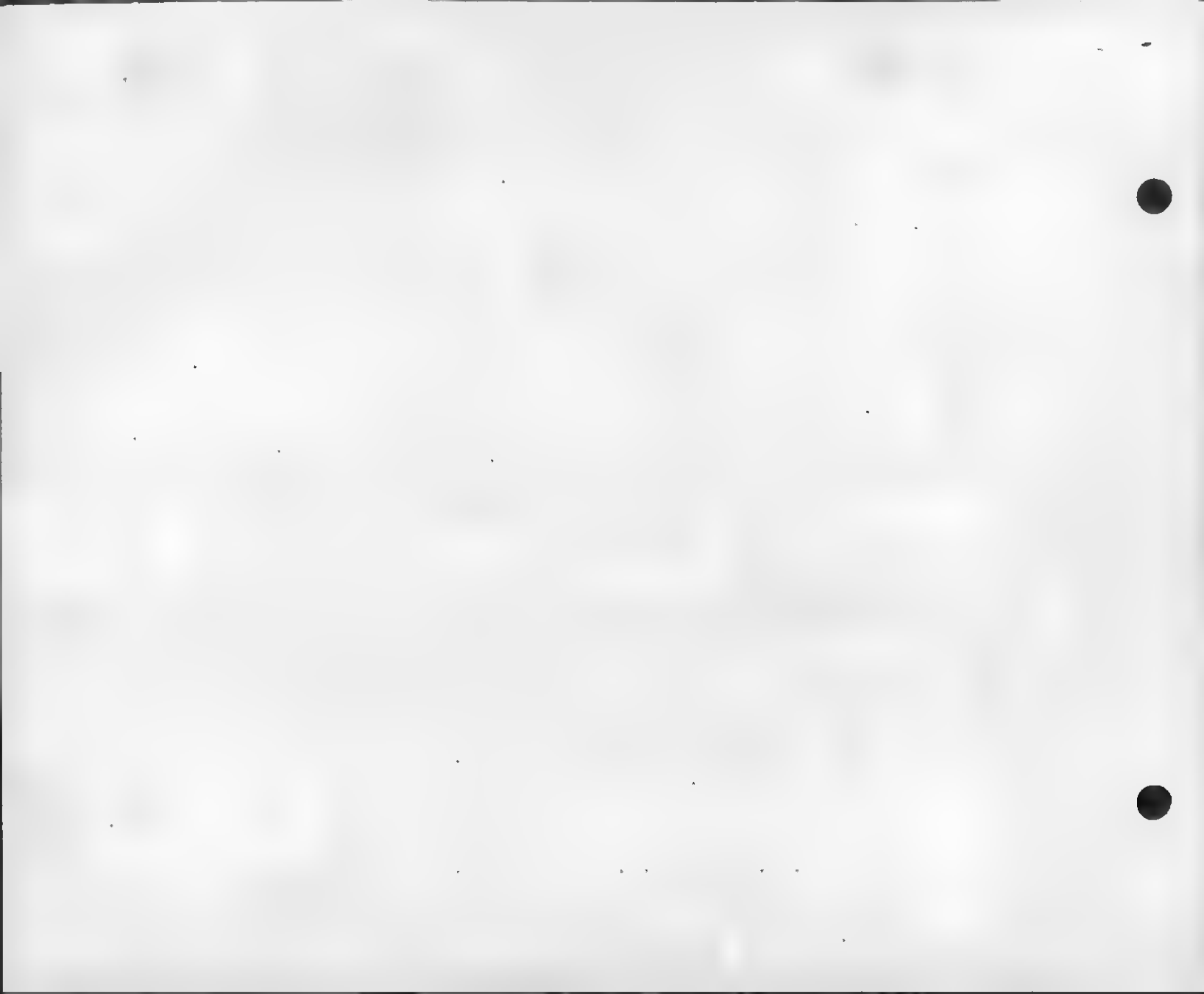
CERTIFICATE OF DEATH

12933

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 9 hrs 7 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital,				d. STREET ADDRESS 13018 Bowie Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Laura Virginia Hartwig				4 DATE OF DEATH Month Sept. Day 6 Year 19 66			
5 SEX Female		6 COLOR OR RACE Cauc		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 6, 1966	
9 AGE in years (last birthday) yrs		10 IF UNDER 1 YEAR Months Days		11 IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11 BIRTHPLACE (County & State or foreign country) Bethesda, Montgomery, Md.	
12 CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME Richard C. Hartwig				14 MOTHER'S MAIDEN NAME Joyce Nagel			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) N/A		16 SOCIAL SECURITY NO N/A		17 INFORMANT Laurel Address Md. Mr. Richard C. Hartwig, 13018 Bowie Road			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intraventricular cerebral hemorrhage DUE TO (b) Prematurity DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 6 , 19 66 , to Sept. 6 , 19 66 , that (X) (we) last saw the deceased alive on Sept. 6 , 19 66 , and that death occurred at 505PM , from causes and on the date stated above							
22a. SIGNATURE 				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 8 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) J. I. LYNCH, M.D.				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-9-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24 FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE SEP 12 1966		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12934

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 15 <u>16 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PET. WALLER'S HOME - PET. WALLER RD</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3527 Runnymede</u> d. STREET ADDRESS <u>3527 Runnymede</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SABINE HAUSER</u> First Middle Last 4. DATE OF DEATH <u>SEPT 9 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/27/1880</u> 9. AGE (in years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lernhard Harburger</u>		14. MOTHER'S MAIDEN NAME <u>Flora Kahn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>12934</u> 17. INFORMANT <u>Mrs. Frances Leser 3527 Runnymede PL NW</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral infarction</u> DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u>cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>gen. arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk</u> <u>Indef</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>9/11/66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1/65</u> to <u>9/8/66</u> that (I) (we) last saw the deceased alive on <u>9/7/66</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen J. Jones M.D.</u>		22b. DATE SIGNED <u>9/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN J. JONES MD</u>		22d. ADDRESS <u>84-Viers Mill Rd. Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9-11-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Mt. Carmel Cemetery Cypress Hills</u>		23d. LOCATION (City, town or county) (State) <u>Queens, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Danzansky & Sons Inc., Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>	



12935

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a COUNTY <u>Rockville</u> <u>Maryland</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Res. denbe before admission) a STATE <u>D.C.</u> b COUNTY <u></u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY <u>16</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home</u>		e STREET ADDRESS <u>1555 Warner Street, N.W.</u>	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type if print) <u>Jimmie Russell Henderson</u>		4 DATE OF DEATH Month <u>Sep.</u> Day <u>24</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 22, 1893</u>
9 AGE (If years lost birthday) <u>73</u> yrs		10 IF UNDER 1 YEAR Months <u></u> Days <u></u>	
11 IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Atiens, Tenn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>General Taylor Russell</u>		14 MOTHER'S MAIDEN NAME <u>Emma Mayfield</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u></u>	
17 INFORMANT <u>Mrs. Louise H. McDougal, Same as #2</u>		Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f (City or town) (County) (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Sept 24</u> 1966, that (I) <u>(was)</u> last saw the deceased alive on <u>Sept 18</u> 1966, and that death occurred at <u>12:20 A.M.</u> , from causes and on the date stated above			
22a SIGNATURE <u>W. Robert Perkins, Jr.</u> M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>9/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Robert Perkins, Jr.</u>	22d. ADDRESS <u>401 - 52 nd Street, NW, Wash, DC</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9/27/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>
24 FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles O.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 23 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 7011 17th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Laura Middle Vandalia Last Hill
4. DATE OF DEATH Month 9 Day 14 Year 1966

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6-16-97 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME E. Byron Hartman 14. MOTHER'S MAIDEN NAME Elizabeth C. Bubb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 557-56-8257 17. INFORMANT Records - Washington Sanitarium & Hospital Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO (b) ANOMIA
DUE TO (c) CARCINOMA OF THE PANCREAS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) WIDE SPREAD METASTASES

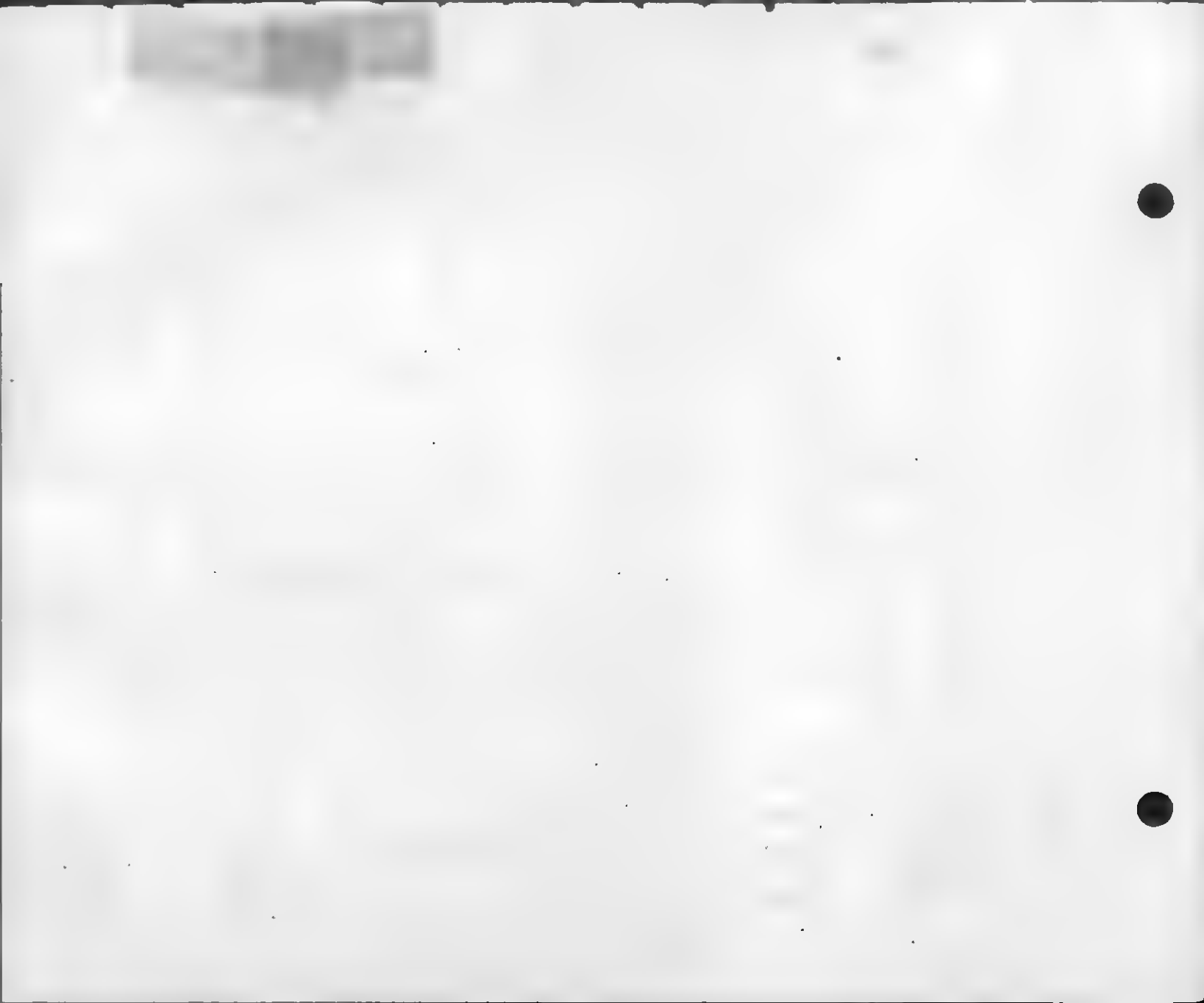
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-21, 1966, to 14 Sept, 1966, that (I) (we) last saw the deceased alive on 14 Sept 1966, and that death occurred at 3:00 PM, from the causes and on the date stated above.

22a. SIGNATURE John L. Ford M.D. 22b. DATE SIGNED 9/14/66
22c. PHYSICIAN'S NAME (Type) JOHN LOUIS FORD M.D. 22d. ADDRESS 831 UNIVERSITY AVE. S.E.

23a. BURIAL, CREMATION, REMOVAL (Specify) Sept 17-1966 23b. DATE THEREOF HEITZ VALLEY 23c. NAME OF CEMETERY OR CREMATORY Amplex Co. Penn 23d. LOCATION (city, town or county) (State)
24. FUNERAL DIRECTOR Waterman Funeral Home ADDRESS 1100 N. ... 25a. REC'D BY REGISTRAR ... 25b. REGISTRAR'S SIGNATURE ... DATE SEP 16 1966 ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please employ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12932

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> d. STREET ADDRESS <u>1514 GLEASON ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN HEAVER HISSEY</u>		4. DATE OF DEATH Month Day Year <u>Sept. 27 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-21</u>
9. AGE (in years last birthday) <u>45</u> yrs.		10. FINDER 1 YEAR FINDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C. 70</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy (McKinnon)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>BEAUFORD H. HISS</u>		Address <u>5412 H St NE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left breast with metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>66</u> , to <u>Sept. 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept. 26</u> , 19 <u>66</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		22b. DATE SIGNED <u>Sept. 27, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/30/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL CEM</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring Md 20910</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>5022 W. 4th St</u>		25b. REGISTRAR'S SIGNATURE _____	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12938

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages (and 7 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death

1 PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN <u>Washington</u> c. RURAL (and give nearest town) <u>Rock Creek Cemetery</u>		2 USUAL RESIDENCE Where deceased lived if institution. Re: death certificate a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN <u>Washington</u> d. RURAL (and give nearest town) <u>Rock Creek Cemetery</u>	
3 NAME OF DECEASED Type or print <u>Percy A. Holmes</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-2-51</u>
9 AGE (last birthday) <u>15</u> years <u>11</u> months <u>19</u> days		10 UNDER 24 HR. <u>19</u> hours <u>19</u> minutes	
11 PATIENT'S OCCUPATION (if deceased during most of working life, even if retired) <u>Housewife</u>		12 C. OF B. OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13 FATHER'S NAME <u>John A. Holmes</u>		14 MOTHER'S MAIDEN NAME <u>Marie Holmes</u>	
15 WAS DECEASED EVER IN ARMED FORCES (yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 INFORMANT <u>Jeanne Overton (Same as above # 2)</u>	
18 CAUSE OF DEATH (Enter cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> 42-2-2 DUE TO (b) <u>Coronary artery disease</u> (c) <u>Other unspecified disease</u>		INTERVIEW WITH AN ATHER <u>Yes</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f CITY OR TOWN (County, State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John A. Holmes</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John A. Holmes</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Sep. 14, 1966</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR <u>Glen Carter</u>		25a REC'D BY REG. STRAR <u>SEP 14 1966</u>	
25b REG. STRAR'S SIGNATURE <u>Charles Judge</u>		25c ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	



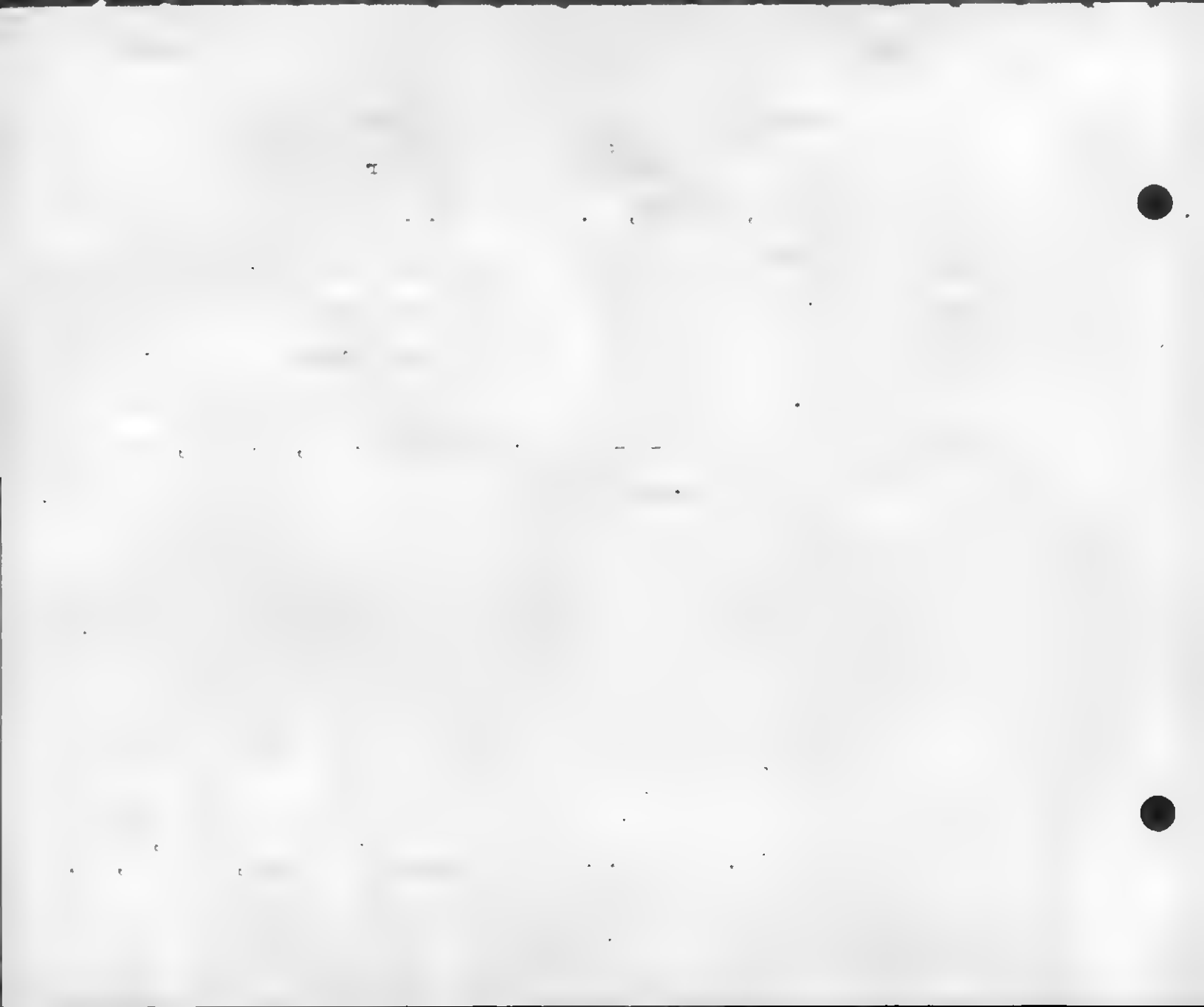
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12939

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Greenbrier</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ronceverte</u>			
c. LENGTH OF STAY in 1b <u>100</u> Days				d. STREET ADDRESS <u>P.O. Box 361</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>National Institutes of Health The Clinical Center, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>David</u> Last <u>Houchins</u>				4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 October 1907</u> 58 yrs.	
9. AGE (In years last birthday) <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Donald J. Houchins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hannah Foglesong</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 1942	
16. SOCIAL SECURITY NO. <u>235-05-9193</u>		17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <u>he</u> (this hospital) attended the deceased from <u>30 May</u> , 19 <u>66</u> to <u>7 Sept</u> , 19 <u>66</u> that <u>we</u> last saw the deceased alive on <u>7 September 1966</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Roland T. Skeel</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>7 September 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Roland T. Skeel, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Ronceverte, West Virginia</u>		24. FUNERAL DIRECTOR <u>Clark E. Wisor, Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the ~~death~~ certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Florida b COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in b 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		d. STREET ADDRESS 6615 9th Avenue N.W.	
3 NAME OF DECEASED (Type or print) First Dwight Middle Eroll Last HUBBARD		4 DATE OF DEATH Month September Day 27 Year 1966	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 31, 1921
9 AGE (in years last birthday) 44 yrs		10 UNDER 1 YEAR Months 10 Days 26	11 UNDER 24 HRS Hours 5 Min 50
Do S.A. OCCUPATION Give kind of work done during most of working life, even if retired) U.S. Navy		12b KIND OF BUSINESS OR INDUSTRY N/A	
13 FATHER'S NAME Dwight K. Hubbard		14. MOTHER'S MAIDEN NAME Vyrl Siron	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1940-1963		16 SOCIAL SECURITY NO 263 24 9900	
17 INFORMANT Bradington, Fla.		18 ADDRESS Mrs. Mary A. Hubbard, 6615 9th Ave. N.W.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the lungs with wide-spread metastases. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Sept. 3 , 19 66 , to Sept. 27 , 19 66 that (X) (we) last saw the deceased alive on Sept. 27 , 19 66 , and that death occurred at 8:15 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>David R. Foreman</i>		22b. DATE SIGNED Sept. 28, 1966	
22c. PHYSICIAN'S NAME (Type) David R. Foreman		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-30-66	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a REC'D BY REGISTRAR DATE 10/1	25b REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

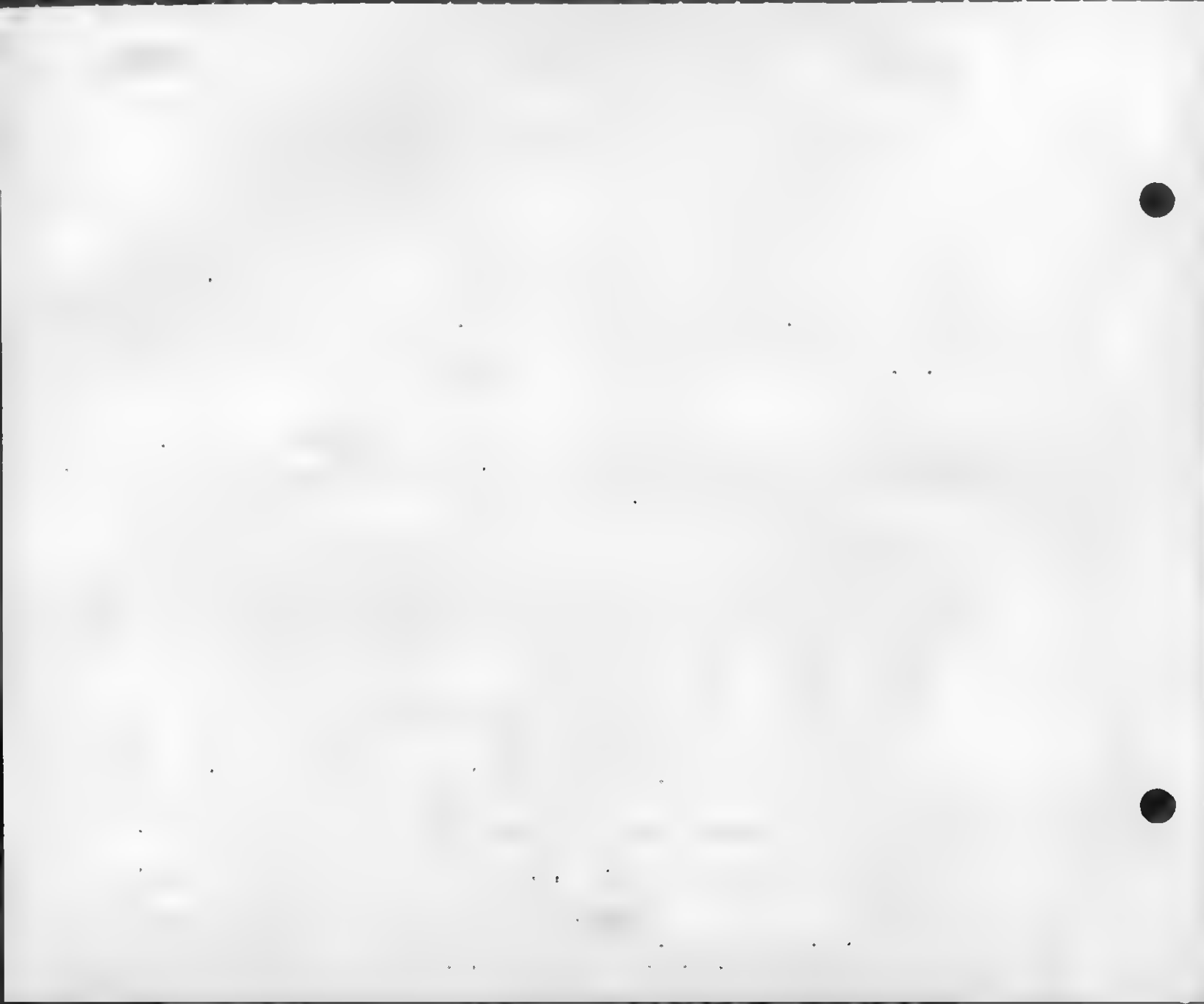
CERTIFICATE OF DEATH

12941

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Naval Hospital		d. STREET ADDRESS 6008 Longfellow Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) David Thomas HUDSON		4 DATE OF DEATH Month Sept. Day 14 Year 9 66	
5 SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 1, 1920
9 AGE (in years last birthday) yrs 46		10 F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11 BIRTHPLACE (County & State or foreign country) Rochester, New York		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 11-7-43 to 8-28-66		16 SOCIAL SECURITY NO 054-14-0501	
17. INFORMANT East Riverdale Address Md. Mrs. Marion Hudson, 6008 Longfellow St.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontocerebellar Tumor DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a))		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 16 , 19 66 , to 14 Sept. , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 Sept. , 19 66 , and that death occurred at 335P M, from causes and on the date stated above.			
22 SIGNATURE Martin Gregor Andersen		22b DATE SIGNED Sept. 15, 1966	
22c PHYSICIAN'S NAME (Type) Martin Gregor Andersen, M.D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION, SHOW (Specify) Burial	23b DATE THEREOF 9/14/66	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N. W. Washington, D.C.		25a REC'D BY REGISTRAR DATE SEP 15 1966	
25b REGISTRAR'S SIGNATURE [Signature]			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

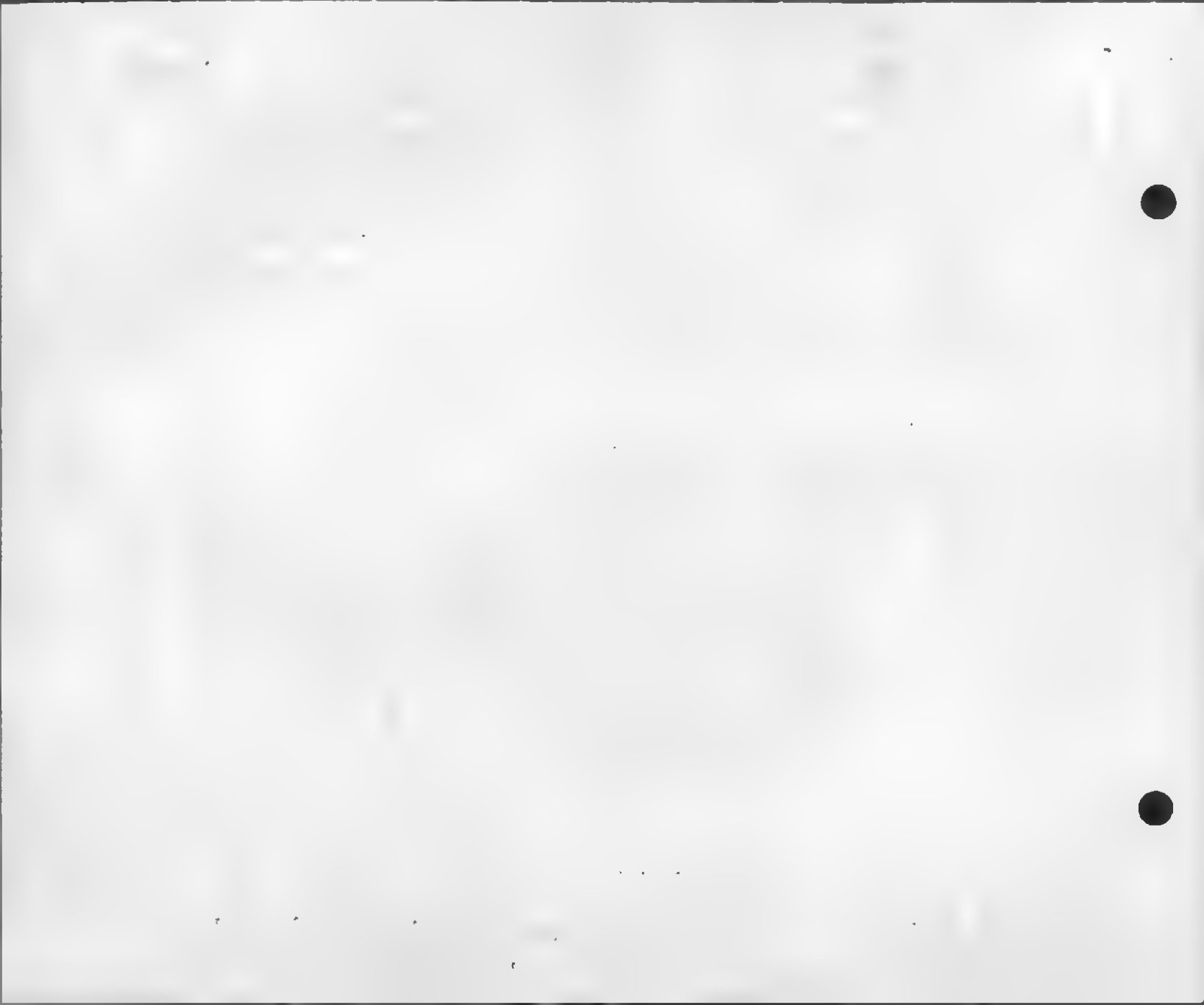
CERTIFICATE OF DEATH

12942

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mrs. Helen Christine Rufford</u>		4 DATE OF DEATH <u>September 9</u> 19 <u>66</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 12, 1900</u>
9 AGE In years (last birthday) <u>66</u> yrs		10 IF UNDER 1 YEAR: Months <u>9</u> Days <u>18</u> Hours <u>15</u> Min <u>00</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		11b KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11c BIRTHPLACE (County & State, or foreign country) <u>Irma, Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Mr. Wells Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Artha Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>478-34-0432</u>	
17. INFORMANT <u>Patient's chart</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c), PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>H.E. and A.S.C.</u> -DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>66</u> , to <u>Sept 8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 8</u> , 19 <u>66</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Marvin Schneider</u>		22b. DATE SIGNED <u>9/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider, M.D.</u>		22d. ADDRESS <u>415 S. 5th St. S.E., Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Minnesota Acacia Pk. Cem</u>	23d. LOCATION (City or town) (County) (State) <u>St. Paul, Minnesota</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Maryland</u>		25. REGISTRATION SIGNATURE <u>Charles Judge</u>	

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12943

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>8 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>735 Ridge Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARY FRANCES IHRIE</u>		4 DATE OF DEATH <u>Sept. 24</u> 19 <u>66</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 27 1894</u>
9 AGE (In years, last birthday) <u>71</u> yrs		10 IF UNDER 1 YEAR: Months <u>1</u> Days <u>24</u> IF UNDER 24 HRS: Hours <u>4</u> Min. <u>15</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		12 BIRTHPLACE (County & State or foreign country) <u>Rockingham, NC</u>	
13 FATHER'S NAME <u>John Francis Cairns</u>		14 MOTHER'S MAIDEN NAME <u>Eva Wathen Branson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u></u>	
17 INFORMANT <u>John R. Ihrie (same as #7)</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c TIME OF INJURY Month, Day, Year <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f (City or town) (County) (State) <u></u>
21. I certify that (1) (this hospital) attended the deceased from <u>Aug. 15, 1966</u> to <u>Sept. 24, 1966</u> , that (2) (we) last saw the deceased alive on <u>Sept. 23, 1966</u> , and that death occurred at <u>8:41 A.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>James R. Coleman MD</u>		22b. DATE SIGNED <u>Sept. 24, 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept 28, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d LOCATION (City or Town) (County) (State) <u>Arlington Va</u>
24 FUNERAL DIRECTOR <u>Funeral Directors, 254 Carroll Rd NW 4C</u>		25a REC'D BY REGISTRAR <u>SEP 27</u> 25b REGISTRAR'S SIGNATURE <u></u>	



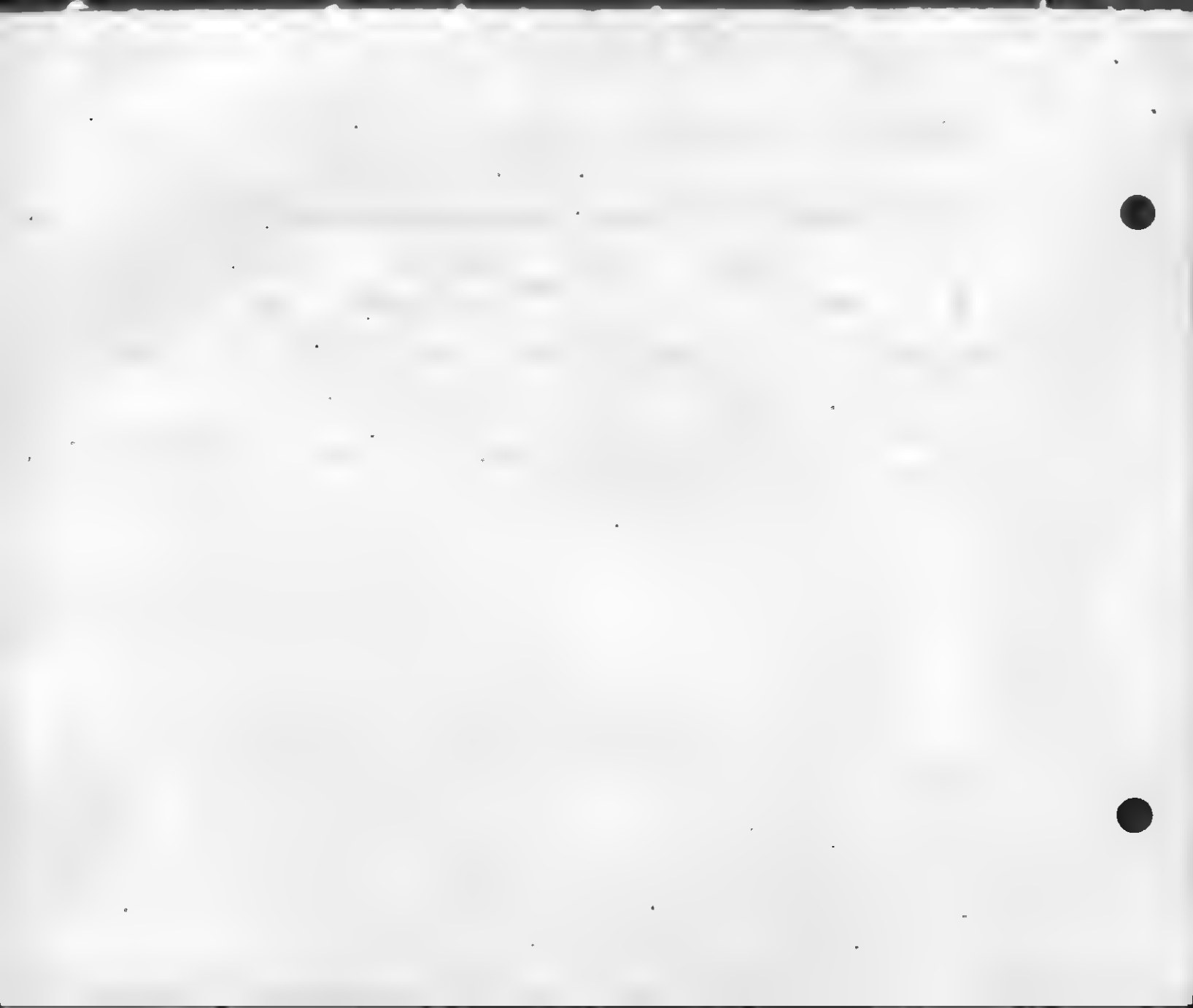
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>2 Mos. 16 Da.</u>				d. STREET ADDRESS <u>5101 Ridgefield Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>							
3. NAME OF DECEASED (Type or print) First <u>RUBY</u> Middle <u>ANN</u> Last <u>JACKSON</u>				4. DATE OF DEATH M. <u>SEPTEMBER</u> Day <u>7th</u> Year <u>1966</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4, 1878</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTRAR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BIBLE INSTITUTE</u>		13. FATHER'S NAME <u>James H. Jackson</u>	
13. FATHER'S NAME <u>James H. Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Poling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>322-28-1766</u>		17. INFORMANT <u>Neice Mrs. Thomas Flavin</u>		Address <u>4800 Dover Rd. Washington, D. C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Thrombosis, basilar artery</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE, 1965</u> , to <u>7 SEPT, 1966</u> , that (I) (we) last saw the deceased alive on <u>7 SEPT 1966</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph J. Wallace</u>				22b. DATE SIGNED <u>7 SEPT. 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. WALLACE, M.D.</u>				22d. ADDRESS <u>5817 LENOX RD BETHESDA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial-transit 9-7-66</u>		<u></u>		<u>Horton Cemetery</u>		<u>Horton, Kansas.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>SEP 9 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12945

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>13 months</u>				d. STREET ADDRESS <u>Springvale Terrace</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springvale Terrace</u>							
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Frances</u> Last <u>Jacquith</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 24, 1904</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Upton, Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George H. Evans</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Bates</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. Richard Jacquith</u>		Address <u>5604 42nd Ave Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 12 HRS.</u> <u>5 YRS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>65</u> , to <u>9/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>66</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John E. Everett</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>				22d. ADDRESS <u>9400 CONN. AV. KENSINGTON</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Spencer, Mass.</u>	
24. FUNERAL DIRECTOR <u>Wm. S. Thompson</u>				25a. REC'D BY REGISTRAR <u>Wm. S. Thompson, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thompson, Inc.</u>	



CERTIFICATE OF DEATH

12946

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN 1b <u>2 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d STREET ADDRESS <u>196 SEMINARY PLACE</u>	
3 NAME OF DECEASED Type or print) <u>HELEN M JARBOE</u>		4 DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1966</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/13/16</u>
9 AGE (In years last birthday) <u>56</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11 BIRTHPLACE (County & State or foreign country) <u>Washington, D. C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George M. Mattingly</u>		14 MOTHER'S MAIDEN NAME <u>Leocadia J. Lally</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> <u>none</u>		16 SOCIAL SECURITY NO. <u> </u>	
17 INFORMANT <u>William D. Jarboe</u>		Address <u>1961 Seminary Place</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u> DUE TO (b) <u>PULMONARY EMPHYSEMA & FIBROSIS</u> DUE TO (c) <u>METASTASIS FROM BREAST CANCER</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LEUKEMIZED METASTATIC BREAST CANCER</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>DECEASED</u> to <u>9-20-66</u> that (I) <u>was</u> last saw the deceased alive on <u>9-19-66</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>John P. Haberlin</u> M.D.		22b DATE SIGNED <u>9-20-66</u>	
22c PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>		22d ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/23/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR <u>The S. H. Hines Company</u>		25a REC'D BY REG. STRAR DATE <u>SEP 21 1966</u>	
25b REGISTRAR'S SIGNATURE <u> </u>		25c REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 thru 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1
- MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12947

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN <u>Tuckersville</u> c LENGTH OF STAY IN TB <u>10 days</u> d STREET ADDRESS <u>1402 Laurel Avenue, Tuckersville, Tenn.</u>		2 USUAL RESIDENCE (Where deceased lived prior to death) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (Outside corporate limits write RURAL and give nearest town) d STREET ADDRESS <u>1402 Laurel Avenue, Tuckersville, Tenn.</u> e RESIDENCE IN A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First <u>Robert</u> Middle <u>Lee</u> Last <u>Johnson</u>		4 DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-1-1911</u>
9 AGE (In years last birthday) <u>55</u>		10 IF UNDER YEAR Month <u>7</u> Day <u>24</u> Hours <u>12</u> Minutes <u>00</u>	
11 A. PATIENT (known or suspected) during most of working life (even if retired) <u>Housewife</u>		12 B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13 FATHER'S NAME <u>Robert Lee Johnson</u>		14 MOTHER'S MAIDEN NAME <u>Marion Johnson</u>	
15 WAS OF LEGAL AGE (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Hospital Records</u>		18 ADDRESS <u>None</u>	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO (b) <u>None</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)	
21a TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	21b INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	21c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d (City or town) (County) (State)
22 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>9-24-1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ADDRESS (City, town, or county) <u>Tuckersville, Tenn.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Sept 27-1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Tuckersville</u>	23d LOCATION (City or town) (County) (State) <u>Tuckersville, Tenn.</u>
24 FUNERAL DIRECTOR <u>Arthur Watters</u>		25a REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>254 Laurel St</u>		25b REGISTRAR'S SIGNATURE <u>Arthur Watters</u>	



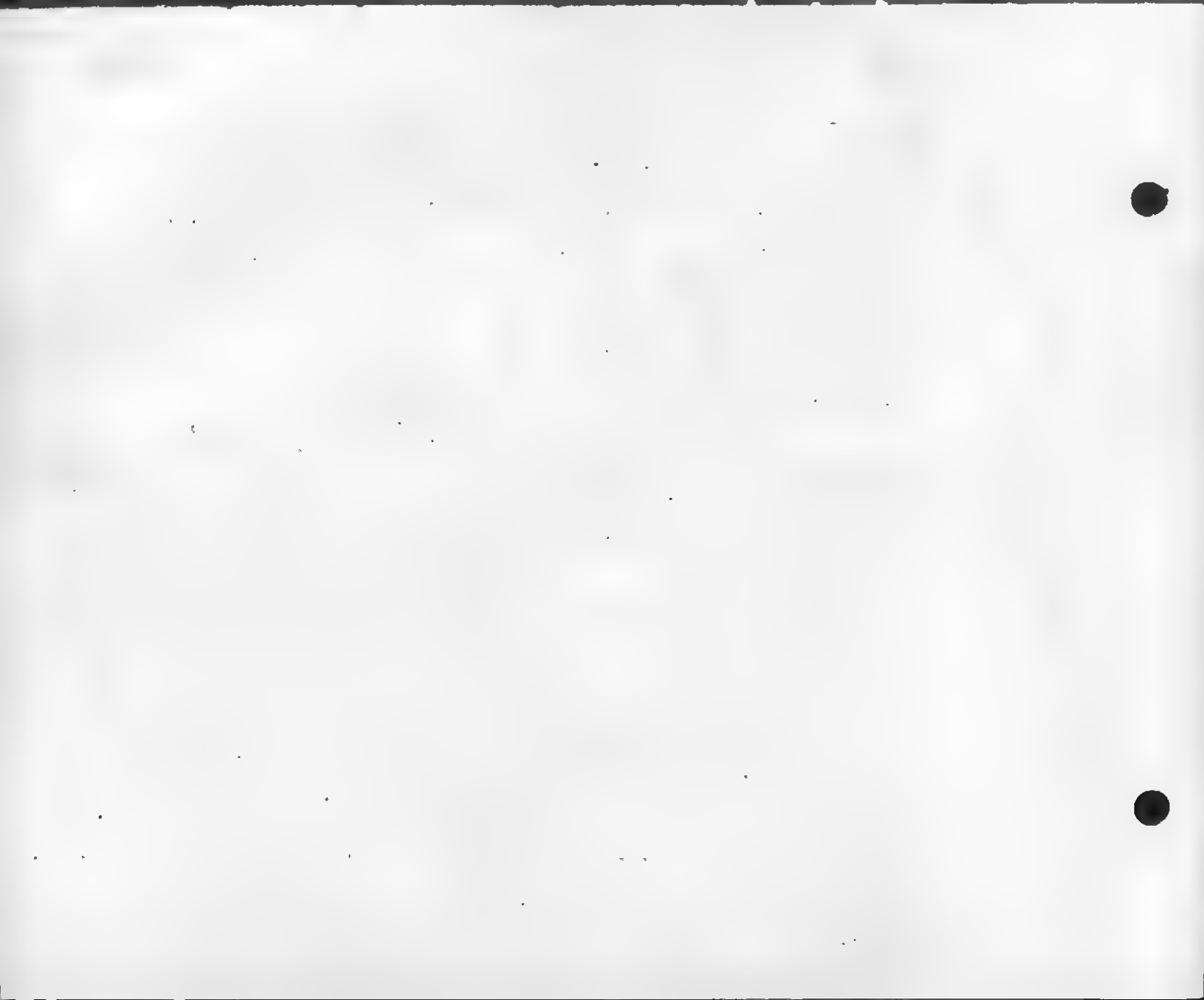
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12948

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>Apt. 5</u> <u>5010 Southern Avenue, S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Middle</u> <u>Last</u> <u>Silvia</u> <u>Catalina</u> <u>Johnson</u>			4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1966</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>Negro</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>25 June 1934</u>		
9. AGE (In years last birthday) <u>32</u> yrs.			10. FUNDING YEAR Months <u>32</u> Days <u>32</u> Hours <u>32</u> Min. <u>32</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Cuba</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Wilbur Barnes</u>			14. MOTHER'S MAIDEN NAME <u>Mildred Haywood</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-52-9120</u>		
17. INFORMANT <u>The Medical Records,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myelogenous leukemia</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>23 September 1966</u> to <u>25 September 1966</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>25 September 1966</u> , and that death occurred at <u>1240M</u> , from the causes and on the date stated above.					
22a. S. SIGNATURE <u>Leroy Pass</u>			22b. DATE SIGNED <u>25 Sept. 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Leroy Pass, M.D.</u>			22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>9/28, 1966</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Fort Myer, Virginia</u>		
24. FUNERAL DIRECTOR <u>Alex Pope</u>			25a. REC'D BY REGISTRAR <u>15th. St. S. E.</u>		
25b. REGISTRAR'S SIGNATURE <u>15th. St. S. E.</u>			25c. DATE <u>25 Sept 1966</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12255

12949

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE PENNA b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALDEN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) DAVID E. JONES		4 DATE OF DEATH Sept 7 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB 27 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11 BIRTHPLACE (County, State or foreign country) Philadelphia, PENNA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME DAVID T. JONES		14 MOTHER'S MARDEN NAME ELIZABETH WHITTE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 162-10-7490	
17 INFORMANT Alice R. Jones		Address Same as #2 wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized A.S. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Diabetes mellitus. Ess. Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 4-27 1966 to 9-7 1966 that (I) (we) last saw the deceased alive on 9-7 1966 and that death occurred at 2:35 PM , from causes and on the date stated above			
22a. SIGNATURE D. H. Bengtson M.D.		22b. DATE SIGNED 9-7-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, BURNING (Specify)	23b. DATE THEREOF 9/10/66	23c. NAME OF CEMETERY OR CREMATOR Holy Cross	23d. LOCATION (City or Town) (County) (State) Yeodon Pa.
24 FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REG. STRAR DATE SEP 10 1966		25b. REG. STRAR'S SIGNATURE J. H. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12950

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>			c. LENGTH OF STAY IN b. <u>5 hrs.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Army Medical Center</u>			d. STREET ADDRESS <u>2000 1st St</u>		
3. NAME OF DECEASED (Type or print) <u>Mr. R. A. Jones</u>			4. DATE OF DEATH <u>Sept 11 1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 1909</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Albert C. Childs</u>			14. MOTHER'S MAIDEN NAME <u>Constance Gibbs</u>		
15. WAS DECEASED EVER IN U.S. ARMY? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>3602</u>		
17. INFORMANT <u>Arthur G. Jones</u>			Address <u>3602 Quesada St. N.W. Washington, D.C.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO (b) _____ CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. AGGRIEVED WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> , 19 <u>66</u> , to <u>Sept 11</u> , 19 <u>66</u> , that (I) last saw the deceased alive on <u>Sept 10</u> , 19 <u>66</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>James W. Egan</u>			22b. DATE SIGNED <u>9/11/66</u>		
22c. PHYSICIAN'S NAME (Type) _____			22d. ADDRESS _____		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>			23b. DATE THEREOF <u>9/12/66</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Coldwell Hill</u>			23d. LOCATION (City, town or county) <u>Beltsville</u> (State) <u>MD</u>		
24. FUNERAL DIRECTOR <u>J. W. Egan</u>			25a. REG'D BY REGISTRAR <u>15000</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
ADDRESS <u>Washington, D.C.</u>			DATE <u>SEP 13 1966</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12951

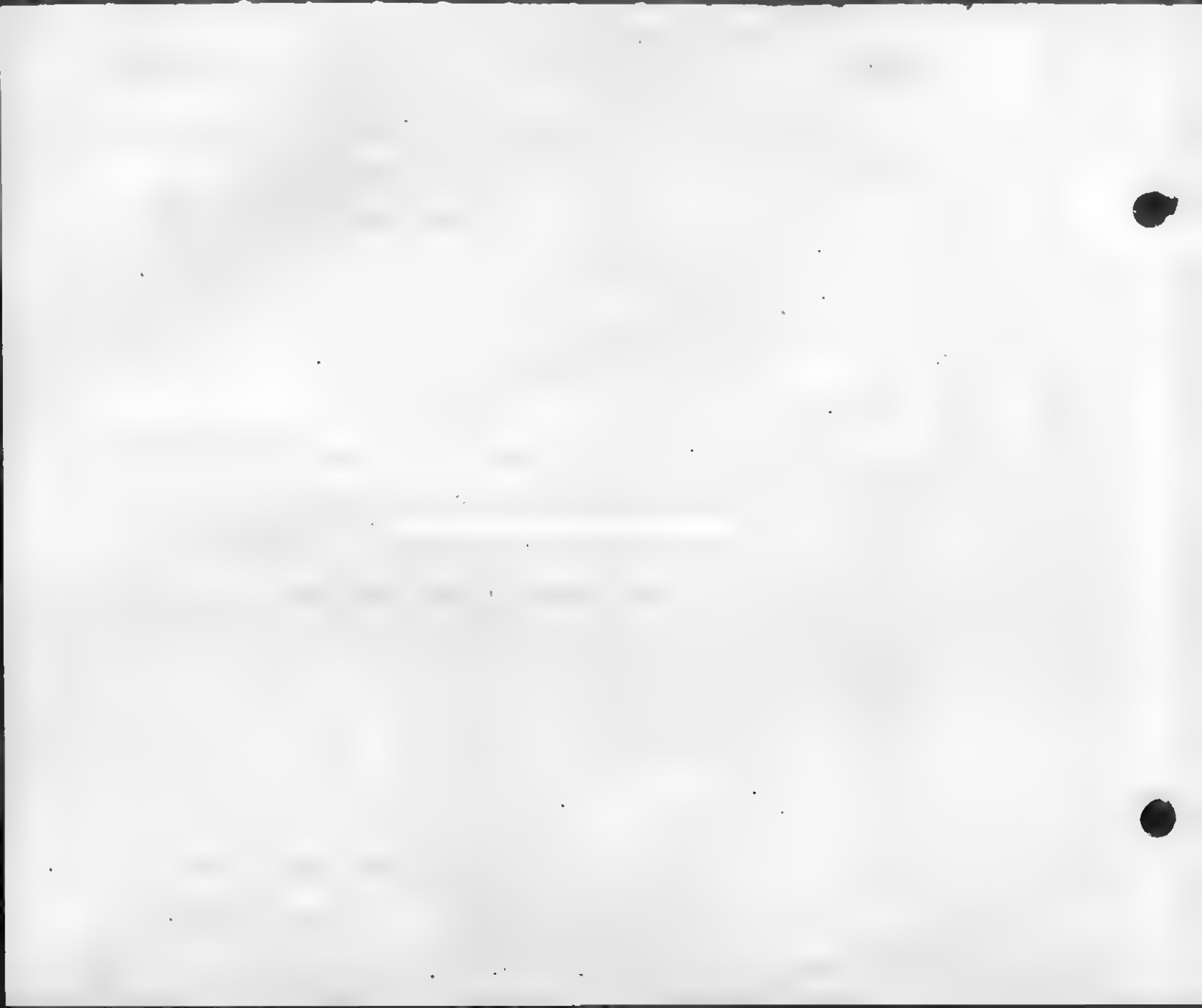
1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brown Heights</u>	
d. NAME OF HOSPITAL, DR. INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital Silver Spring</u>		d. STREET ADDRESS <u>648 PONTAN STREET</u>	
3 NAME OF DECEASED (Type or print) <u>William M. Jones</u>		4 DATE OF DEATH <u>September 24 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 1919</u>
10a. OCCUPATION (Give kind of work done during most of working life even if retired) <u>Chief Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>GA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William W. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>4-77-211-11</u>	
17. INFORMANT <u>James H. Sully</u>		Address <u>1835 Eye St NW Washington DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute suppurative mediastinitis & pleuritis</u> DUE TO (b) <u>perforated esophagus</u> DUE TO (c) <u>Hiatal hernia & peptic esophagitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>3 weeks</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cordiac arrest</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-23, 1966</u> to <u>9-24, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-24 1966</u> , and that death occurred at <u>3:30 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>James H. Sully</u>		22b. DATE SIGNED <u>9-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Sully</u>		22d. ADDRESS <u>1835 Eye St NW Washington DC</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-24-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington DC</u>
24. FUNERAL DIRECTOR <u>SA. H. Sully</u>		25a. REC'D BY REGISTRAR <u>131-111111</u>	
25b. REGISTRAR'S SIGNATURE <u>131-111111</u>		DATE <u>9-24-66</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit may be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12952
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>5007 McCall Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Henry Jones</u>				4. DATE OF DEATH <u>Sept 17 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 21, 1921</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive parts</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Rowland A. Judge</u>		14. MOTHER'S MAIDEN NAME <u>Clara Thornton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>029-10-4856</u>		17. INFORMANT <u>Mrs. Louise Judge</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemopericardium (400 cc) & Cardiac tamponade (port wall left</u> DUE TO (b) <u>Ruptured myocardial infarction ventricle)</u> DUE TO (c) <u>Coronary thrombosis (left circumflex)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/17/66</u> , 19 <u>66</u> , to <u>9/17/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/17/66</u> 19 <u>66</u> (and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Morton Shapiro</u> M.O.				22b. DATE SIGNED <u>9/17/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Morton Shapiro, M.D.</u>	
22d. ADDRESS <u>8107 Eastern Ave., Silver Spring, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Sept. 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forestdale Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Malden, Massachusetts</u>		25a. REC'D BY REGISTRAR	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25b. REGISTRAR'S SIGNATURE <u>Rowles Judge</u>		DATE <u>SEP 17 1966</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12953

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>726665156</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home Care Hospital</u>				d. STREET ADDRESS <u>769 Highland Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>I.</u> Last <u>KANODE</u>				4 DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1966</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-13-81</u>		9 AGE (In years last birthday) <u>85</u> yrs	10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13 FATHER'S NAME <u>Charles W. Randall</u>				14 MOTHER'S MAIDEN NAME <u>Martha Kanode</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>no</u> <u>None</u>		16 SOCIAL SECURITY NO <u>270-44-7946-D</u>		17. INFORMANT <u>Esther K. Allen</u>		Address <u>909 Highland Drive Silver Spring, Md.</u>	
18a. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>congestive heart failure</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 m. 5.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Fracture neck 2 R. femur</u> (b) <u>2) Decubiti ulcers</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) <u>Slip/fall at home</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>3 PM 7/26/66</u>		20c. TIME OF INJURY Month, Day, Year <u>7/26 1966</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>SILVER SPRING</u>		20f. (County) <u>MONT.</u>		20g. (State) <u>MD.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>7/26, 1966</u> , to <u>9/15, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/15, 1966</u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above	
22a. SIGNATURE <u>Norman Oliver</u>				22b. DATE SIGNED <u>9-15-66</u>		22c. PHYSICIAN'S NAME (Type) <u>NORMAN OLIVER</u>	
22d. ADDRESS <u>1400 SPRING ST. S.S. Mont Md.</u>				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>1400 SPRING ST. S.S. Mont Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR <u>John B. Thomas</u>		24a. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REG. STRAR <u>1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. W. Jones</u>	

Closed with medical examiner's file

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12951

1 PLACE OF DEATH a COUNTY Montgomery MARY AND		2 USUAL RESIDENCE Where deceased lived at last before death a. STATE Washington, D.C. COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN b 2 hours	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		e STREET ADDRESS 6800 Georgia Ave. N.W.	
3 NAME OF DECEASED First Middle Last Maria Pauls Karras		4 DATE OF DEATH Month Day Year September 20 1966	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/11/94
9 AGE (in years last birthday) 72		10 IF UNDER 1 YEAR Months Days Hours Min	
11 STATE (If not in U.S. give foreign date of birth) Housewife		12 PLACE OF BIRTH (State or foreign country) Messick, Virginia	
13 FATHER'S NAME John Pauls		14 MOTHER'S MAIDEN NAME unavailable	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO unavailable	
17 INFORMANT Daughter, Mrs. Margaret O'Boyle		Address 12907 Margot Dr Rockville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO _____ CONDITIONS, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-21-1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR 11		25a REC'D BY REGISTRAR	
ADDRESS 11651		25b REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 23 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, & removal, and in any event, within 72 hours after death.

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12955

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town.) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address.) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>111 NEWELL ST.</u>	
3 NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>Genevieve</u> Last <u>KEATINGE</u>		4 DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1966</u>	
5 SEX <u>FEMALE</u>	6 CO. OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/4/36</u>
9 AGE in years (last birthday) <u>69</u> yrs		10 FINDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION Give kind of work done during most of working life, even if retired. <u>Ret. Statistical Clerk U.S. Govt.</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11 BIRTHPLACE (Country & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Maurice J. O'Connor</u>		14 MOTHER'S MAIDEN NAME <u>Ella V. Cunningham</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Mrs. David C'Connor</u>		Address <u>921 Wendell St. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DLE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DLE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>46 hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1966</u> to <u>Sept 2, 1966</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>Sept 1, 1966</u> , and that death occurred at <u>9:44 A.M.</u> from causes on and on the date stated above			
22a SIGNATURE <u>Bernard A. Fitzgerald</u>		22b DATE SIGNED <u>9-2-66</u>	
22c PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d ADDRESS <u>217 WINDY BLVD. SILVER SPRING MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Sept. 7, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24 FUNERAL DIRECTOR <u>Clark E. Wison</u>		25a REC'D BY REGISTRAR <u>SEP 5 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Warren E. Dunham, Inc.</u>		25c REGISTRAR'S SIGNATURE <u>Silver Spring, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

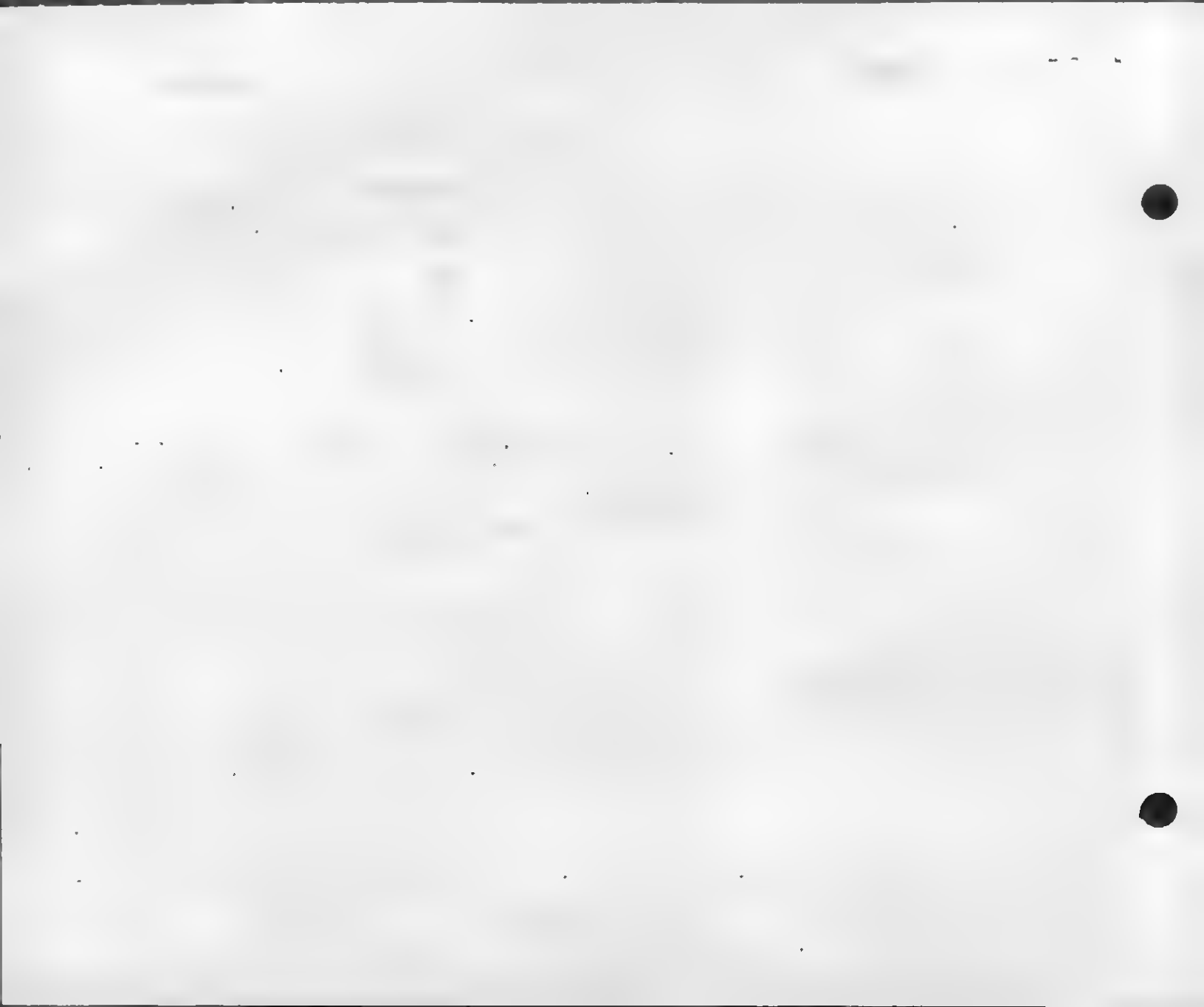
CERTIFICATE OF DEATH

12956

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN It 47 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Apt. 107 1320 Nicholson St., N.W. /	
3 NAME OF DECEASED (Type or print) First Middle Last Samuel Lee KEMP		4 DATE OF DEATH Month Day Year Sept. 7 19 66	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 19, 1943
9 AGE in years last birthday 22		IF UNDER 1 YEAR Months Days Hours Min 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11 BIRTHPLACE (Country & State, or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Kemp		14. MOTHER'S MAIDEN NAME MARTHA GLODWIN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 8-5-64 to 9-7-66		16 SOC. A. SECURITY NO 578 56 0141	
17 INFORMANT Apt. 107 Washington D.C.		18. MOTHER'S MAIDEN NAME Mrs. Delores Kemp, 1320 Nicholson St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Serum Hepatitis / Bronchopneumonia and hepatitis of unknown etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospita) attended the deceased from Jul. 22 , 19 66 , to Sept. 7 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Sept. 7 , 19 66 , and that death occurred at 4:15A M, from causes and on the date stated above			
22a. SIGNATURE Francis C. Johnson M.D.		22b. DATE SIGNED 8 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) Francis C. Johnson, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL (CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9-12-1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR DATE SEP 13 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

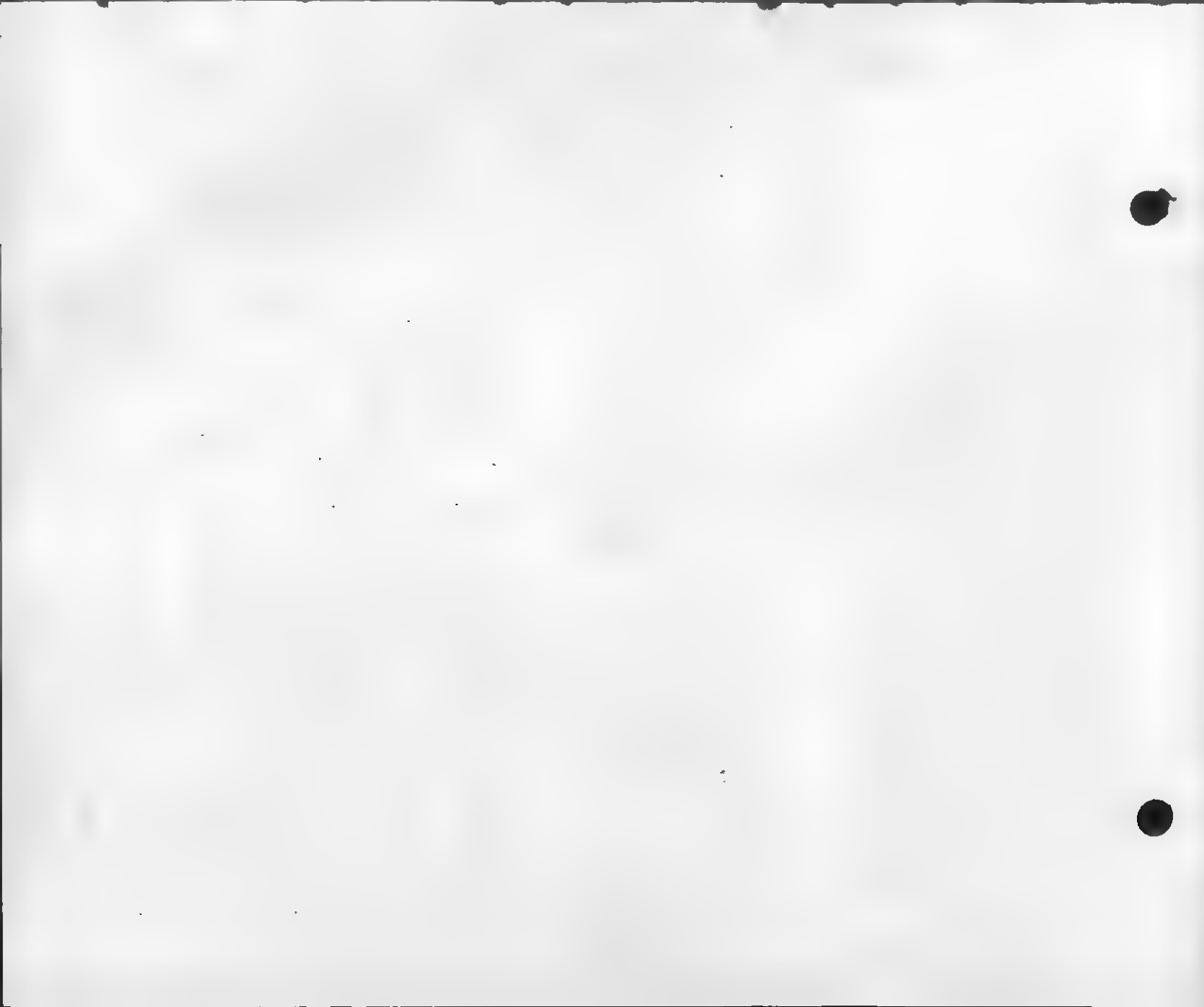
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>6414 SANDY STREET</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRS HOME 2101 FAIRLAND RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MILDRED AGATHA KENNEDY</u>	4. DATE OF DEATH <u>SEPT 22 1966</u>	5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 10 1895</u>	
9. AGE (in years last birthday) <u>71 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>22</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>TRINIDAD WEST INDIES</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM A. GUY</u>		14. MOTHER'S MAIDEN NAME <u>BODINGTON, ROSA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARJORIE J. FISCHER</u>		Address <u>LAUREL, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitostatic Carcinoma</u> (c) <u>Carcinoma Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 yr -</u> <u>2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> , 19 <u>66</u> to <u>9/21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>66</u> , and that death occurred at <u>10:25</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS <u>Laurel, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 26, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Md.</u>	
24. FUNERAL DIRECTOR <u>F. Lawrence Jones & Associates, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEF</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12958

1. PLACE OF DEATH a. COUNTY <u>UNITED STATES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>81 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXXXXX XXXXXX XXXX</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HO-WARD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>308 Burnt Mills Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NICHOLAS</u> First Middle Last		4. DATE OF DEATH <u>9</u> <u>28</u> <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5/17/81</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Boyoris</u>		14. MOTHER'S MAIDEN NAME <u>Catherine (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>282-10-8320</u>		17. INFORMANT <u>Mrs. A'donna Ratchelder</u> Address <u>308 Burnt Mills Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> (b) <u>ASHD</u> (c) <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>July 29, 1966</u> to <u>April 28, 1966</u> that (I) (we) last saw the deceased alive on <u>April 27, 1966</u> and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Bernard A Fitzgerald</u>				22b. DATE SIGNED <u>9-25-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>				22d. ADDRESS <u>217 Univ. Blvd E Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u> <u>4434 Georgia Ave.</u> <u>Bernard E. Humphrey, Jr.</u> <u>Silver Spring, Md.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



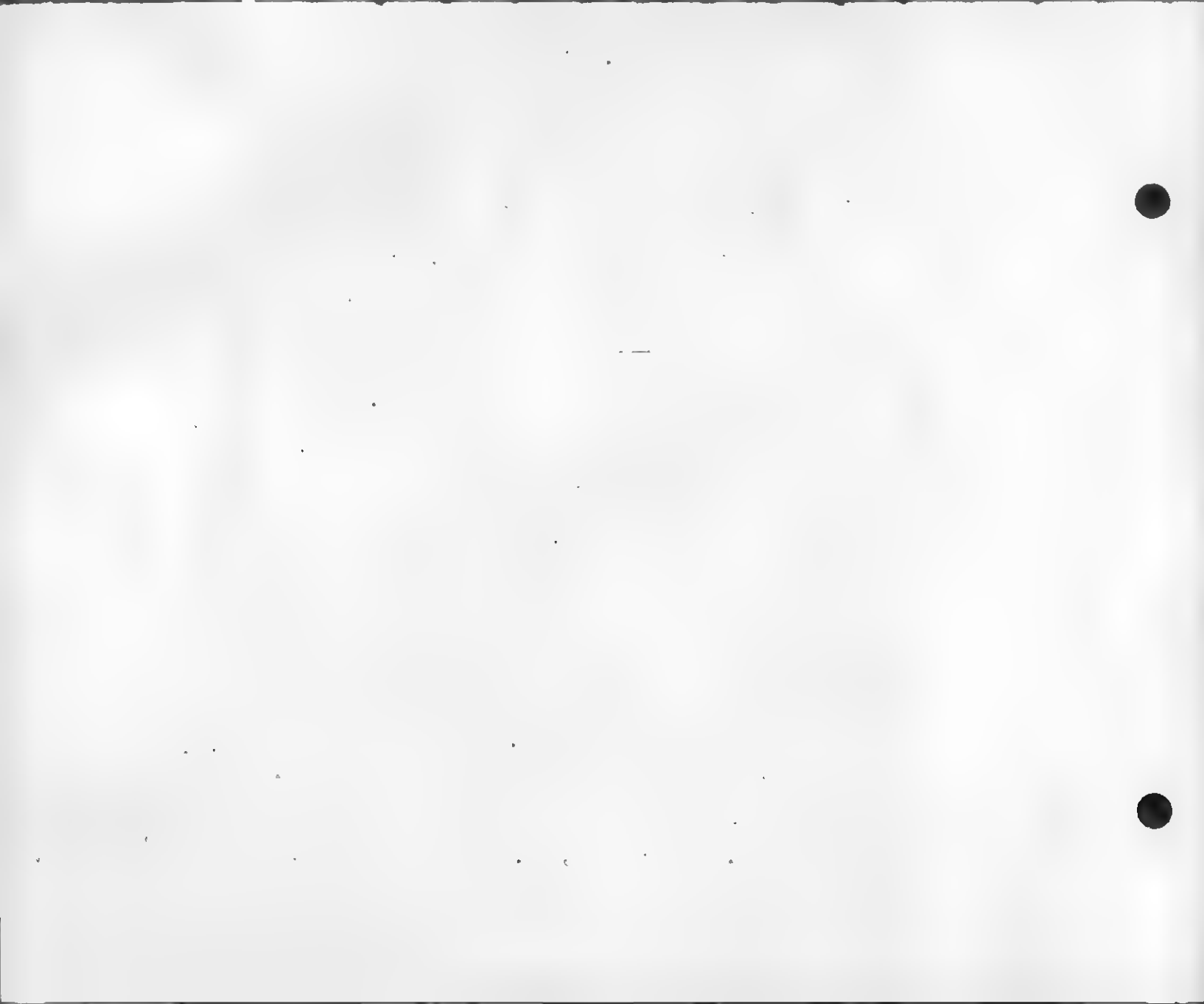
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12959

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McLean</u> d. STREET ADDRESS <u>6661 Tennyson Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Peter Christian Kessinger</u>			4. DATE OF DEATH Month Day Year <u>September 7 19 66</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 September 1958</u>	9. AGE (in years last birthday) <u>7 yrs.</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Arizona</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frederick Kessinger</u>			14. MOTHER'S MAIDEN NAME <u>Dale K. Knox</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative septicemia</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Lymphocytic Leukemia</u> OUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>31 August</u> , 19 <u>66</u> , to <u>7 September</u> 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7 September 19 66</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Norman S. Lichtenstein</u>				22b. DATE SIGNED <u>7 September 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Norman S. Lichtenstein, MD.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-10-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>---</u>			
23d. LOCATION (City, town or county) (State) <u>TUCSON ARIZONA</u>		24. FUNERAL DIRECTOR ADDRESS <u>W.W. Chambers & Co 517-11 St NW Wash DC</u>					
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>SEP 17 1966</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

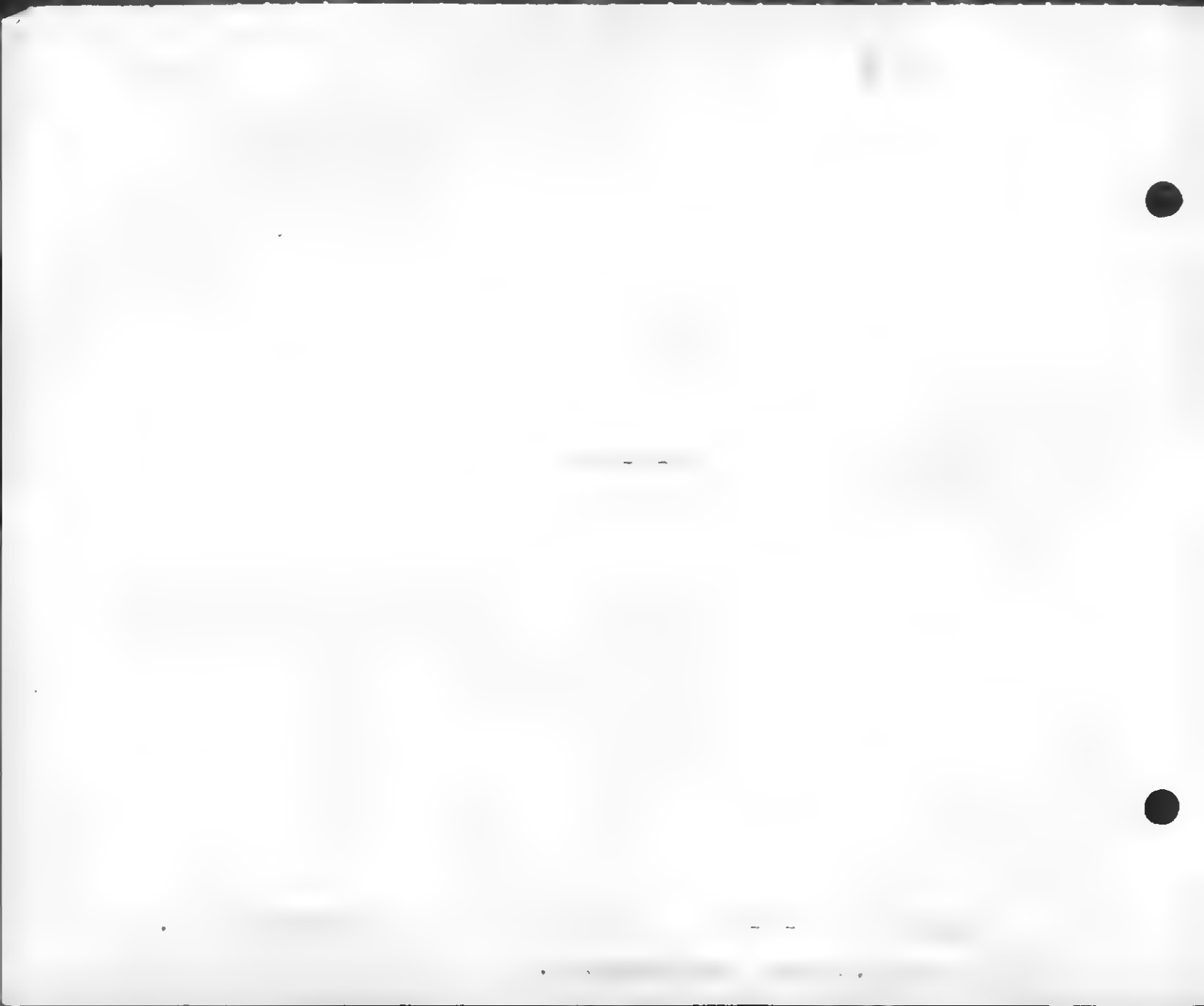
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12960

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN <u>BALTIMORE</u> c. LENGTH OF STAY IN <u>11 days</u>		2 USUAL RESIDENCE (Where deceased lived before death) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3 NAME OF HOSPITAL OR INSTITUTION (If not hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>314 GRANDIN AVE.</u> e. RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4 NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>BARBER</u>		4 DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/17/1895</u>
9 AGE (last birthday) <u>71</u> years <u>0</u> months <u>0</u> days		10 BIRTHPLACE (State or foreign country) <u>Virginia</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John W. Barber</u>		14 MOTHER'S MAIDEN NAME <u>Mary Ann Barber</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>215-54-5124</u>	
17 INFORMANT <u>John W. Barber</u>		Address <u>Baltimore, Md.</u>	
18 CAUSE OF DEATH (Enter by cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infection, Multiple Pulmonary</u> DUE TO (b) <u>Pulmonary Embolization</u> DUE TO (c) <u>Fracture Left Hip</u> Conditions (if any) which gave rise to immediate cause (a), stating the underlying cause as: <u>Fracture Left Hip</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Coronary arteriosclerotic heart disease with infarction, old</u>			9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18) <u>Fall & fracture of left hip & knee in 30 x 60</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)
20f (City or town)		20g (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John W. Barber</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) <u>1919 5th St. N.E. S.W.</u>	
22. DATE SIGNED <u>SEP 13 1966</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>9-13-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d LOCATION (City or Town) (County) (State) <u>Gad thersburg, Md.</u>
24 FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
25a REC'D BY REGISTRAR <u>SEP 15 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12961

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 300 Reading Avenue				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RLRA, and give nearest town) Rockville d. STREET ADDRESS 300 Reading Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) HARRIET ANN CLAGETT KINGDON First Middle Last				4 DATE OF DEATH Sept. 3, 1966 Month Day Year											
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Mar. 10, 1877		9 AGE (In year last birthday) 89 yrs		10 UNDER 1 YEAR Months Days		11 UNDER 24 HRS Hours Min			
10a USUAL OCCUPATION Give kind of work done during most of working life even if retired) School Teacher				10b KIND OF BUSINESS OR INDUSTRY Retired				11 BIRTHPLACE (County & State, or foreign country) Rockville, Maryland				12 CITIZEN OF WHAT COUNTRY? U. S.			
13 FATHER'S NAME Richard A. Clagett						14 MOTHER'S MAIDEN NAME Ann M. Ricketts									
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 216-46-0444				17 INFORMANT Daughter Address Same as Item 2.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Myocardial Infarction												INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None														19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		20g (City or town) (County) (State)		20h (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/4</u>, 19<u>57</u>, to <u>9/3</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>8/30</u>, 19<u>66</u>, and that death occurred at <u>8:30</u> AM, from causes and on the date stated above															
22a SIGNATURE <i>[Signature]</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b DATE SIGNED 9/4/66					
22c PHYSICIAN'S NAME (Type) STEPHEN N. JONES						22d ADDRESS 809 Veirs Mill Road Rockville, Maryland									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-6-66		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d LOCATION (City or Town) (County) (State) Rockville, Maryland					
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland ADDRESS						25a. REC'D BY REGISTRAR SEP 8 1966				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12962

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c LENGTH OF STAY in 1b <u>5 days</u>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Frederick</u>		d STREET ADDRESS <u>100, Franklin St.</u>	
3 NAME OF DECEASED (Type or print) <u>Henry Wagner</u> First <u>Henry</u> Middle <u>Wagner</u> Last <u>Wagner</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-22-97</u> 69
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Frederick</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>NEW YORK, N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Henry Wagner</u>		14 MOTHER'S MAIDEN NAME <u>Ellen Ryan</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>Daughter</u>	
17 INFORMANT <u>Daughter</u>		Address	

B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, massive</u> DUE TO (b) <u>coronary arteriosclerosis with thrombosis</u> DUE TO (c) <u>last</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOT BY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c TIME OF INJURY Month, Day, Year hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town)	(County)	(State)
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>66</u> , to <u>Sept 14</u> , 19 <u>66</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Sept 13</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> A.M. from causes and on the date stated above		
22a SIGNATURE <u>Dr. E. D. Delawater</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED <u>SEP 14, 1966</u>
22c PHYSICIAN'S NAME (Type) <u>DR. E. D. DELAWATER</u>	22d ADDRESS <u>215 S. BALTIMORE ST. BALTIMORE, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Sept 17 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Saint Mary's Church Cemetery</u>
23d LOCATION (City or town)	(County)	(State)
24 FUNERAL DIRECTOR <u>Arthur W. Walters</u>	25a RECEIVED BY REGISTRAR <u>Charles Judge</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



12963

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY Rockingham	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY (in days) 61 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Broadway		d. STREET ADDRESS Route #2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lawrence Eugene Kline		First Middle Last		4. DATE OF DEATH September 11 19 66		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 September 1926	
9. AGE (in years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarry Worker		10b. KIND OF BUSINESS OR INDUSTRY Mining Company		13. FATHER'S NAME Neff Kline		14. MOTHER'S MAIDEN NAME Naomi Neff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-32-0811		17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enterobacter Pneumonia DUE TO (b) Bone Marrow Hypoplasia DUE TO (c) Lymphocytic Lymphosarcoma						INTERVAL BETWEEN ONSET AND DEATH 6 Days 1 month 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 12 July , 19 66 , to 11 Sept. , 19 66 , that (X) (we) last saw the deceased alive on 11 September 19 66 , and that death occurred at 9:30M , from the causes and on the date stated above.							
22a. SIGNATURE Jerry L. Spivak		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 11, 1966	
22c. PHYSICIAN'S NAME (Type) Jerry L. Spivak, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		22f. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-12-66		23b. DATE THEREOF 9-12-66		23c. NAME OF CEMETERY OR CREMATORY Cherry Grove Cem.		23d. LOCATION (City, town or county) (State) Broadway, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



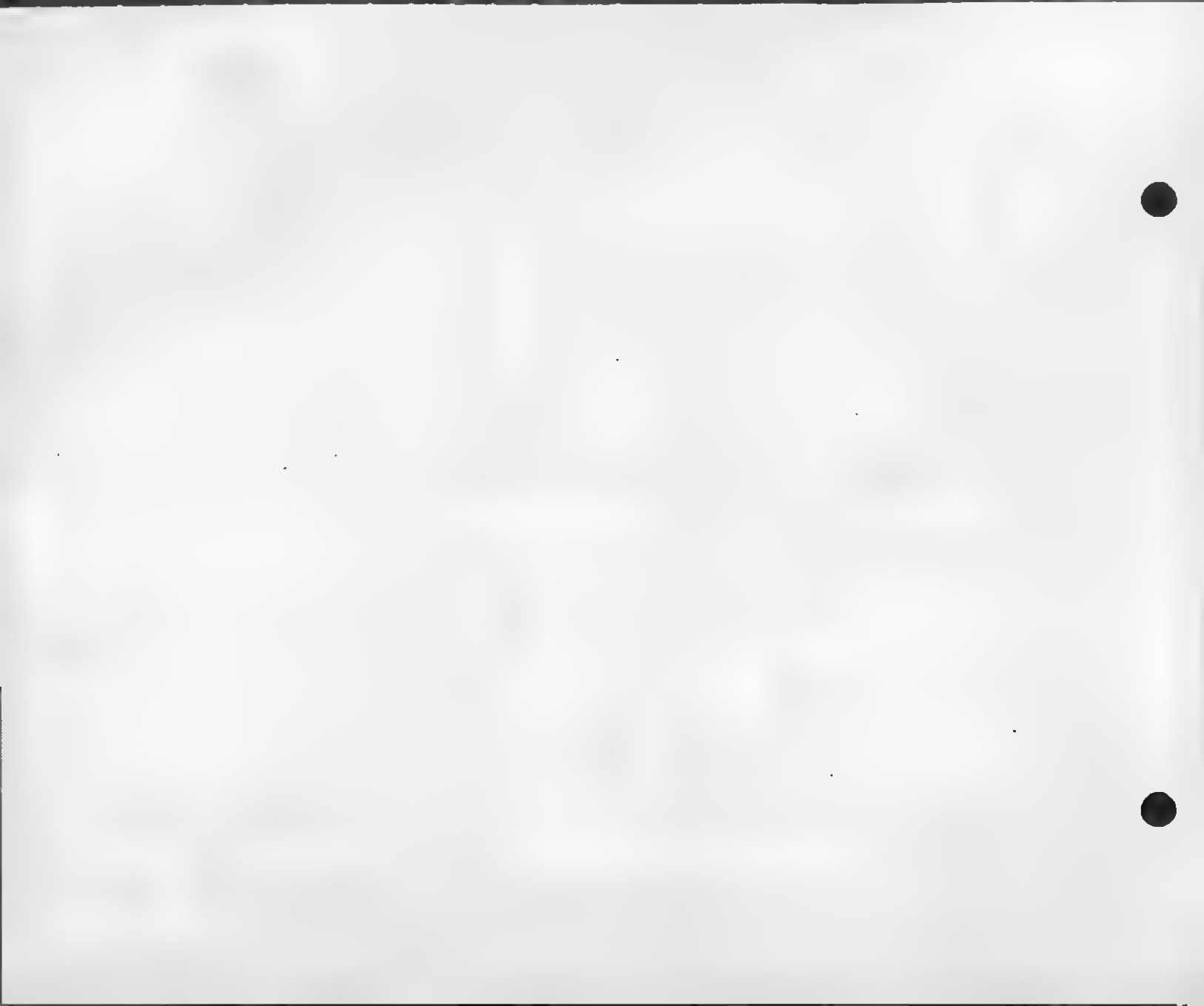
CERTIFICATE OF DEATH

12964

1. PLACE OF DEATH a. COUNTY Montgomery County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 7340 Hardin Ave.	
3. NAME OF DECEASED (Type or print) Simon		4. DATE OF DEATH Month: Sept, Day: 27, Year: 1966	
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY air conditioning	
11. BIRTHPLACE (County & State or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - unknown		14. MOTHER'S MAIDEN NAME - unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO 151-01-5907	
17. INFORMANT Mrs. Alberta Blum, daughter, 10315 Haywood Jr, Sil Spg, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO 4-1-66 (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 27 Sept, 1966, to 27 Sept, 1966 that (I) (we) last saw the deceased alive on 27 Sept, 1966, and that death occurred at 12:00 PM, from causes and on the date stated above.			
22a. SIGNATURE <u>George A. Armstrong</u> M.D.		22b. DATE SIGNED 9-27-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-30-66	23c. NAME OF CEMETERY OR CREMATORY Arl. Natl. Cem.	23d. LOCATION (City or Town) (County) (State) Arl., Va.
24. FUNERAL DIRECTOR B. J. ...		25a. REC'D BY REGISTRAR DATE OCT 1 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12965

1. PLACE OF DEATH
a. COUNTY Md.

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) 10 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 days

3. NAME OF DECEASED (Type or print) Harold L. Kniedler

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7/1/1903

9. AGE (In years last birthday) 3 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State or foreign country Mo. Harrison Co. Mo.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harold V. Kniedler

14. MOTHER'S MAIDEN NAME Emma Kniedler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes, give number and dates of service)

17. INFORMANT Harold V. Kniedler Address 1111 1/2 N. 1st St. Harrison, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction

18b. DUE TO 11-12-1966

18c. DUE TO Obstructive Coronary Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.

20f. City or town, (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1966 to 25 Sept. 1966, that (I) (we) last saw the deceased alive on 19 Sept. 1966, and that death occurred at Mo. from the causes and on the date stated above

22a. SIGNATURE Gary Traylor, Md.

22b. DATE SIGNED 25 Sept. 1966

22c. PHYSICIAN'S NAME (Type) Gary Traylor, Md.

22d. ADDRESS 1111 1/2 N. 1st St. Harrison, Mo.

23a. BURIAL, CREMATION, REMOVAL (Specify) 9-27-66

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY St. Joseph

23d. LOCATION (City, town or county) (State) Harrison, Mo.

24. FUNERAL DIRECTOR'S SIGNATURE Gary Traylor

25a. REC'D BY REG. STRAR Gary Traylor

25b. REGISTRAR'S SIGNATURE

DATE SEP 25 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12966

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission): a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		d. STREET ADDRESS 7601 Gaylord Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Joanne Patricia KOESTER		4 DATE OF DEATH Month Day Year September 17 19 66	
5 SEX Female	6 COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 March 1964
9 AGE (In years last birthday) 2 yrs		F UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (County & State or foreign country) Jacksonville Beach, Fla.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Frederick H. KOESTER		14. MOTHER'S MAIDEN NAME Eileen R. BOBB	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO -----	
17. INFORMANT Frederick H. KOESTER 7601 Gaylord Dr.		Address Annandale, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause as: (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from September 13 1966 to Sep 17 1966 , that (b) (we) last saw the deceased alive on Sept 17 1966 , and that death occurred at 1215 AM , from causes and on the date stated above			
22a. SIGNATURE John J. O'BRIEN		22b. DATE SIGNED 1966 September 17,	
22c. PHYSICIAN'S NAME (Type) John J. O'BRIEN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 9/20/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Tyson Wheeler 1331 E. Montgomery Ave, Rockville Maryland		25a. RECD BY REGISTRAR DATE SEP 20 1966	25b. REGISTRAR'S SIGNATURE J. J. Judge

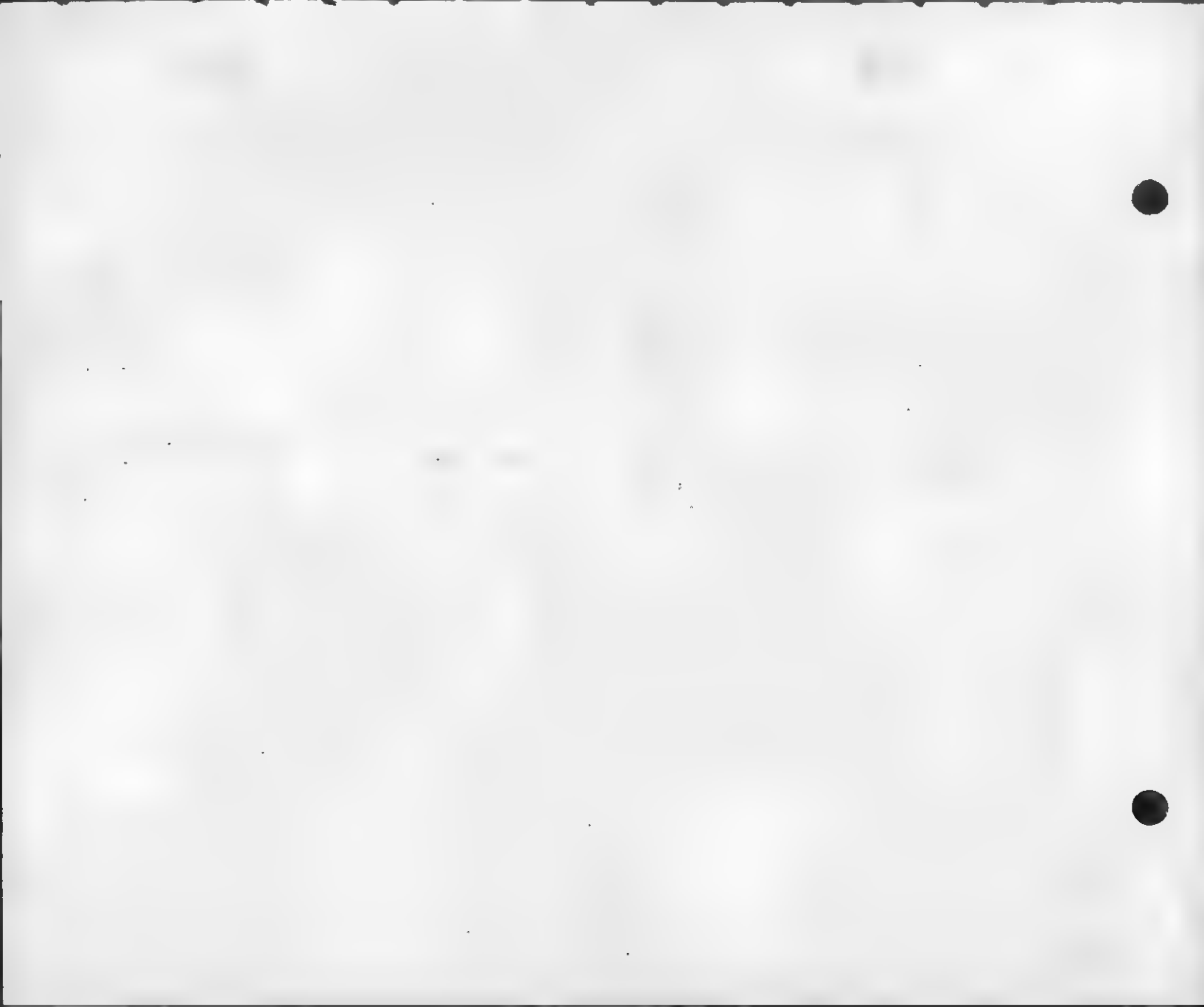


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 1296

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN ID <u>42 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>215 UNIVERSITY BLVD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELEANOR D. KCHLER</u>		4. DATE OF DEATH <u>SEPTEMBER 11</u> 19 <u>66</u>		5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1/17/13</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John J. Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Sadie McMullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Jean J. Ryan</u> Address <u>3019 Pioneer Ave. Pittsburgh, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>66</u> , to <u>9-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-11</u> , 19 <u>66</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>9-12-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Bernard A. Fitzgerald</u>	
22d. ADDRESS <u>217 UNIV BLVD E, SIL SP, MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Sep. 15, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Queen of Heaven Cemetery</u>		23d. LOCATION (City, town or county) <u>Pittsburgh, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

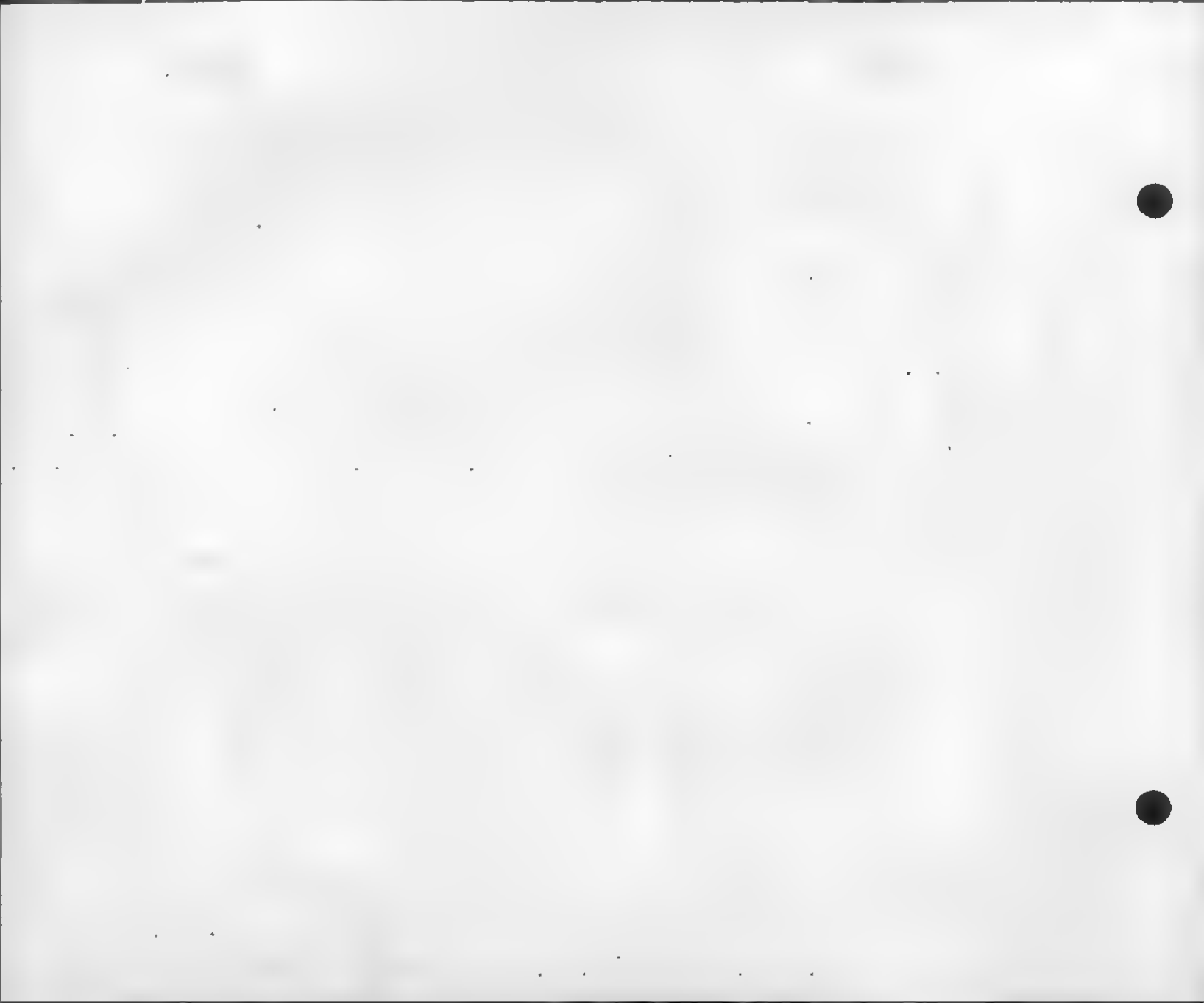
CERTIFICATE OF DEATH

12968

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <u>Vermont</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Germanstown</u>		c LENGTH OF STAY IN lb	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Northfield</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Barry Order Nursing Home</u>		d STREET ADDRESS <u>29 Highland Ave.</u>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED Type of print: <u>LEON</u> <u>B</u> <u>KROMER</u>		4 DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>6-25-1876</u>
9 AGE in years (last birthday) <u>90</u> yrs		10 UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Army - Retired</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Napolean B. Kromer</u>		14 MOTHER'S MAIDEN NAME <u>Rosetta Sudlick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) <u>Yes</u> <u>I & II</u>		16 SOCIAL SECURITY NO <u>577-64-4703</u>	
17 INFORMANT <u>Mrs. Jane K. Kean-3825 Warren St., NW.</u>		Address <u>Wash. DC.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hydropneumonia</u> DUE TO (b) <u>Advanced arteriosclerosis</u> DUE TO (c) <u> </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Astasia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>years</u>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 17, 1962</u> to <u>Sept 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>3 Sept 1966</u> , and that death occurred at <u>7:30 M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>John S. Farwell</u>		22b. DATE SIGNED <u>Sept 6, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Boyd S. M.D.</u>		22d ADDRESS <u>20720</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>9-7-1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph J. Souter's Sons, Inc.</u>		25a REC'D BY REGISTRAR <u>SEP 9 1966</u>	
ADDRESS <u>1130 11th St. N.W., Wash. DC.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12969

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If not in corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY (If in hospital, write number of days; if in institution, write number of months) <u>2 1/2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carey Chase Nursing and Convalescent Center</u>				d. STREET ADDRESS <u>1401 Blair Mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Kane</u> Last <u>Kane</u>				4 DATE OF DEATH <u>SEPT. 4</u> 19 <u>66</u>			
5 SEX <u>Fe</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>June 15 1892</u>	
9 AGE (In years last birthday) <u>74</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>V. J. Russia</u>	
13. FATHER'S NAME <u>Gernard Kammermacher</u>				14 MOTHER'S MAIDEN NAME <u>Sarah Metz</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16 SOCIAL SECURITY NO <u>none</u>		17 INFORMANT <u>Bernard Kane</u> 10101 address <u>BRUCK, DR.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC Heart disease 10 yrs</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>Aug 19 66</u> to <u>Sept 4 19 66</u> that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>66</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Morton W. Shapiro</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Morton W. Shapiro, MD</u>		22b. DATE SIGNED <u>9/4/66</u>					
22d. ADDRESS <u>8107 Eastern Ave Silver Spring</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>HATTSVILLE MD</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		ADDRESS <u>4717 9th St NW</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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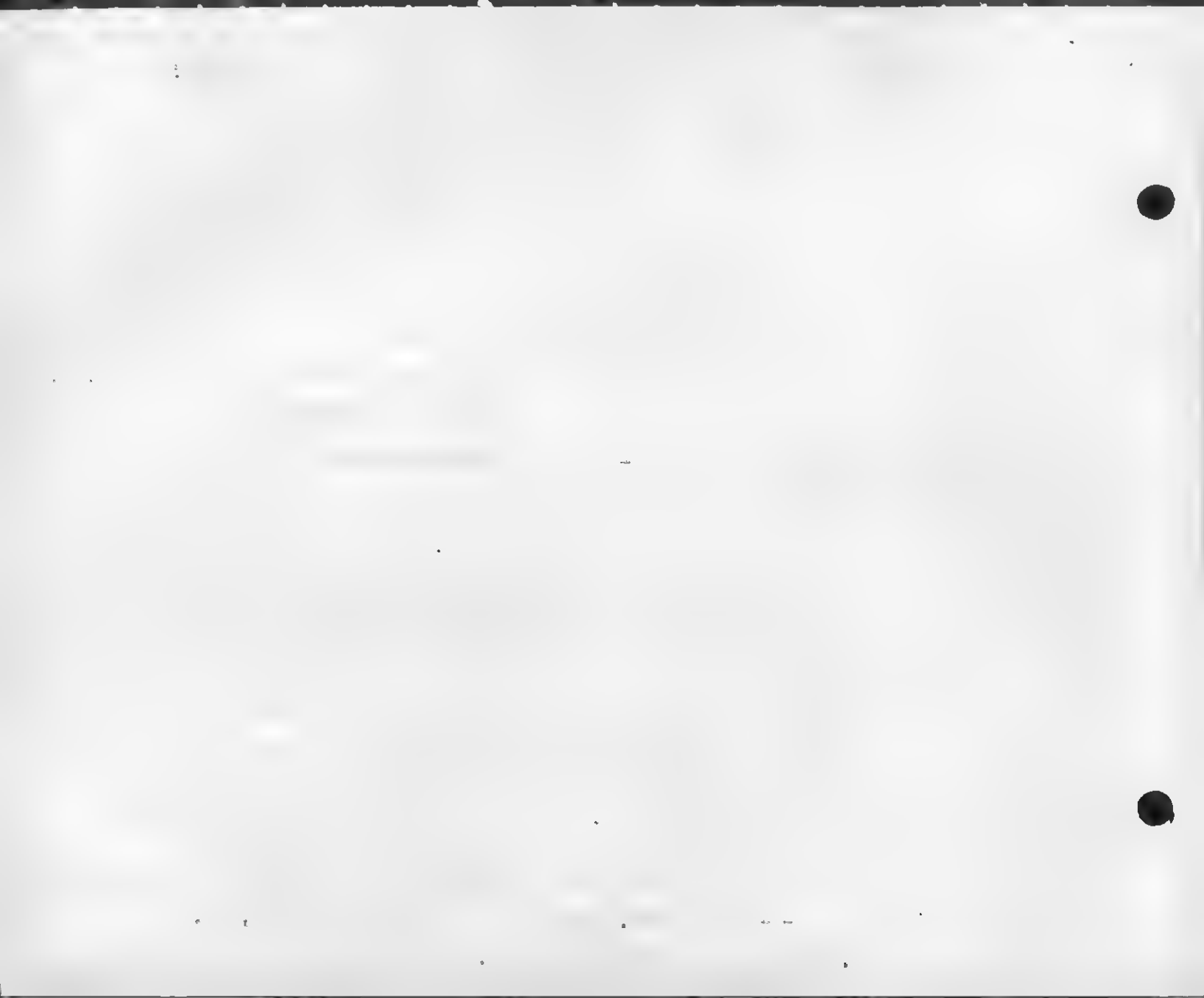
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Kuykendall</u> , Middle <u>Millie</u> , Last <u>Effie</u>		4. DATE OF DEATH Month <u>8</u> , Day <u>2</u> , Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/1916</u>
9. AGE (In years, last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> , Days <u>0</u>	11. IF UNDER 24 HRS Hours <u>0</u> , Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Reaves</u>		14. MOTHER'S MAIDEN NAME <u>Sarah? Macafee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CACHEXIA</u> DUE TO (b) <u>ABDOMINAL CARCINOMATOSIS</u> DUE TO (c) <u>ADENOCARCINOMA OF GALL BLADDER</u> 19. INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>3 MONTHS</u> <u>1 YR.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY: Month, Day, Year Hour <u>0</u> min <u>0</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1966</u> to <u>SEPT 2 1966</u> , that (I) (we) last saw the deceased alive on <u>SEPT 2 1966</u> , and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles S. Whitaker</u>		22b. DATE SIGNED <u>SEP 7 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, MD.</u>		22d. ADDRESS <u>CLARKSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-5-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	23d. LOCATION (City or town) (County) (State) <u>Sunshine, Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1966</u>	
ADDRESS <u>Laytons ville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Lillian Landis, mother, called. I cleared up the matter.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #16 Film #G380 9/20/66 pc

CERTIFICATE OF DEATH

12971

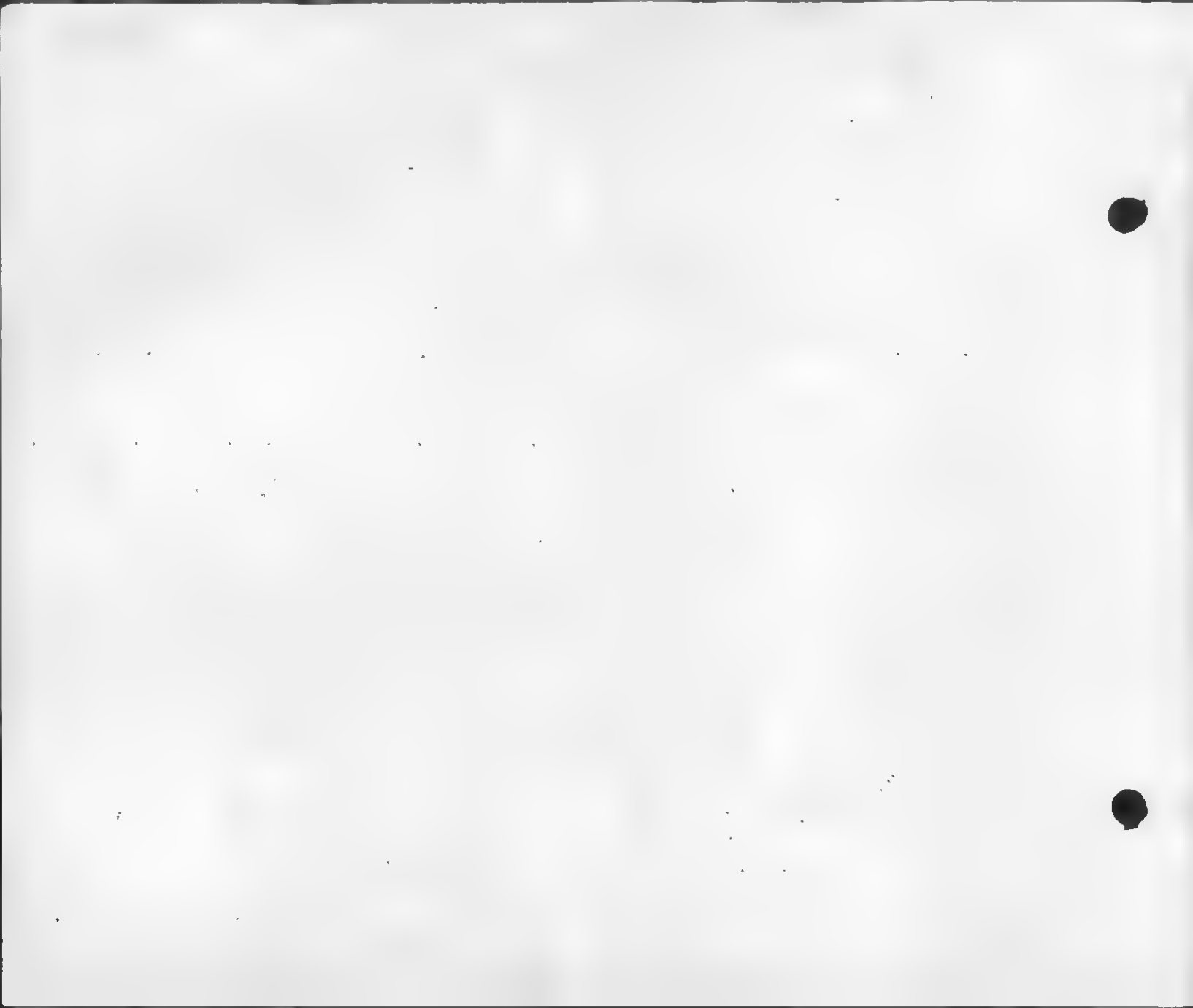
1 PLACE OF DEATH a COUNTY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN TB D.C.A.	
d NAME OF HOSPITAL OR INSTITUTION (If at in hospital give street address) Maryland Hospital		e STREET ADDRESS 1502 New York Drive	
3 NAME OF DECEASED (Type or print) First Middle Last C. Rubie Landis		4 DATE OF DEATH Month Day Year 1966 9 14	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-10-19 **/**/**** 04 **62
9 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b KIND OF BUSINESS OR INDUSTRY Restaurant	
11 BIRTHPLACE (County & State or foreign country) Frederick Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
3 FATHER'S NAME C. Rubie Landis		14 MOTHER'S MAIDEN NAME Norma Bennett	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 578 26 3413	
17 INFORMANT Mrs. Lillian Landis- See- 2 abcd		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis with myocardial infarction</i> DUE TO (b) <i>Coronary heart disease with prior infarctions</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 30 min 7 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 1966 9 14		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____, 1966, to Sept 14, 1966, that (I) (we) last saw the deceased alive on Aug 29, 1966, and that death occurred at 11:45 M. from causes and on the date stated above.			
22a SIGNATURE <i>Sydney Leoenthal</i>		22b DATE SIGNED Sept 14, 1966	
22c PHYSICIAN'S NAME (Type) Sydney Leoenthal		22d ADDRESS 9210 Colson Rd., Silver Spring Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 19-1966	
23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24 FUNERAL DIRECTOR J.R. Etchison & Son		25a REC'D BY REGISTRAR DATE 9-15-66	
ADDRESS 7 Frederick, Md. 21701		25b REGISTRAR'S SIGNATURE <i>J. J. Jones</i>	

CERTIFICATE OF DEATH

12972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Jesse Melvin Lane		4. DATE OF DEATH Month Day Year 9 2 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1909
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Concrete Products		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard F. Lane		14. MOTHER'S MAIDEN NAME Susan Mary Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213-03-8075	
17. INFORMANT Mrs. Jesse M. Lane		Address Dickerson, Md. R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 March, 1966 , to 2 Sept, 1966 , that I last saw the deceased alive on 2 Sept, 1966 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md.	
PHYSICIAN'S NAME (Type) Gordon M. Smith		DATE SIGNED 2 Sept 66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/66	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W C Hutter		ADDRESS Barnesville, Md.	
24a. REC'D BY REGISTRAR SEP 7 1966		24b. REGISTRAR'S SIGNATURE J Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u> <u>11 YRS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>934 PHILADELPHIA AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>934 PHILADELPHIA</u>									
3. NAME OF DECEASED (Type or print) <u>THOMAS E. LAWLER</u>		4. DATE OF DEATH Year <u>1966</u> Month <u>9</u> Day <u>28</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH <u>2-18-01</u>		9. AGE (In years, if UNDER 1 YEAR; last birthday) <u>65</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
Months	Days	Hours	Min.										
11. TYPE OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>THOMAS P. LAWLER</u>									
14. MOTHER'S MAIDEN NAME <u>IDA SHEPPARD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>MARGARET LAWLER SAME AS #2</u>									
17. INFORMANT <u>MARGARET LAWLER</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of the Tongue</u> (b) <u>1411</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>INTERVAL BETWEEN ONSET AND DEATH 18 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. CITY OR TOWN <u>SILVER SPRING</u> <u>MD.</u>									
21. I certify that (I) (was hospital) attended the deceased from <u>1959</u> , to <u>9-28</u> , 19 <u>66</u> that (I) <u>last</u> saw the deceased alive on <u>9-15</u> 19 <u>66</u> , and that death occurred at <u>7:00p</u> from the causes and on the date stated above		22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>9-28-66</u>									
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602 Georgia Ave. Silver Spring Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>									
23d. LOCATION (City, town or county) <u>SILVER SPRING</u> (State) <u>MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Ball</u>		25a. REC'D BY REGISTRAR <u>3821-147</u> 25b. REGISTRAR'S SIGNATURE									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u># 3 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bella Vista Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>3006 Lindale Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>CALVERT</u> Last <u>LEIZEAR</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Leizear (deceased)</u>					14. MOTHER'S MAIDEN NAME <u>Kate Calv rt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>N/A</u>			16. SOCIAL SECURITY NO. <u>218-16-2096-A</u>		17. INFORMANT <u>Mrs. Lucile Hixson, 259 Congressional Lane, Rockville, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Unknown cause</u> DUE TO (b) <u>Congestive heart failure bronchopneumonia</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) None</u> (b) <u>2) Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/66</u> , 19 <u>66</u> , to <u>9/2/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/1/66</u> 19 <u>66</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Patrick Jameson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/2/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Patrick Jameson</u>					22d. ADDRESS <u>11718 Georgia Ave, Wheaton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>Sept 5, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union Cemetery, Burtonsville, Maryland</u>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</u>					25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12975

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN <u>Cherry Chase</u> (and give nearest town)		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>3525 Woodbine Street</u>		d STREET ADDRESS <u>3525 Woodbine St.</u>	
3. NAME OF DECEASED (Type or print) <u>North Thomas Lewis</u>		4 DATE OF DEATH <u>Sept 27 1966</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/6/1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
13. FATHER'S NAME <u>Louis Patterson Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Gertrude Dudley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>718-12-8859</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to Hanging</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hung Self by clothes line around neck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5 9/27/66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cherry Chase, Mont. Md.</u> (County) _____ (State) _____	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		DATE SIGNED <u>9/27/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bethesda, Maryland</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial-transit 9-28-66</u>		22b. DATE THEREOF _____	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine View Cemetery</u>		22d. LOCATION (City, town or county) <u>Rocky Mount, No. Carolina</u> (State) _____	
23 FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		24a. REG'D BY REGISTRAR <u>DATE OCT 2 1966</u>	
		24b. REGISTRAR'S SIGNATURE _____	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for his files. 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12976

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>D onx 52</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN ID <u>9-16-66, 9-26-66</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. STREET ADDRESS <u>1000 Jessup Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Lieberman</u> Last <u>Lieberman</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/97</u>
9. AGE (In years last birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Abraham Schenholz</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Chameides</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hosp. records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1966</u> to <u>Sept 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 26</u> 19 <u>66</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>Sept 26, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		22d. ADDRESS <u>1019 University Blvd East</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-28-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETH DAVID CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>ELMONT - L.I. - N.Y.</u>
24. FUNERAL DIRECTOR <u>Benjamin Denzansky & Sons</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1966</u>	
ADDRESS <u>5501-14th St. N.W., Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12977

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 15 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Althea Woodland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE OF MARYLAND District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4905 Greenway Dr. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha H. Lindsay		4. DATE OF DEATH Month Sept. Day 30 Year 1966		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1876	
9. AGE (In years last birthday) 89		10. FUND 1 YEAR Months 11 Days 19 Hours 66 Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Irvin		14. MOTHER'S MAIDEN NAME Bertha St. Mann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 178-14-3075		17. INFORMANT Grace Lindsay Address Green Acres, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) ARTERIOSCLEROSIS, GENERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 17 MO. 2 Y.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from APRIL , 1961, to SEPT 30 , 1966, that (I) (we) last saw the deceased alive on SEPT. 30 , 1966, and that death occurred at 12 M, from the causes and on the date stated above.			
22a. SIGNATURE Lee M. Curtis		22b. DATE SIGNED 9-30-66		22c. PHYSICIAN'S NAME (Type) LEE M. CURTIS	
22d. ADDRESS 807 WISCONSIN AVE., BETHESDA, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 10/3/66		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Jos. Gavler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR DATE OCT 5 1966			
25b. REGISTRAR'S SIGNATURE John J. George					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

129978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And if any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c LENGTH OF STAY IN 1b <u>17 days</u>		2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>8018 Park Lane</u>	
3 NAME OF DECEASED (Type or print) First <u>Lesa</u> Middle <u>U.</u> Last <u>Lingo</u>		4 DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Can</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>31 4/1895</u>
9 AGE (In years last birthday) <u>71</u>		F UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of workable life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State or foreign country) <u>Montgomery, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leslie Lingo</u>		14. MOTHER'S MAIDEN NAME <u>Lena T. Lingo</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>215-48-5873</u>	
17 INFORMANT <u>Charles M. Lingo</u> Address <u>Item 2.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adrenal hemorrhage and insufficiency</u> DUE TO (b) <u>shock</u> DUE TO (c) <u>sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/13/1966</u> to <u>9/13/1966</u> , that (I) (we) last saw the deceased alive on <u>9/13/1966</u> , and that death occurred at <u>1:45 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>J. P. McCarrick</u>		22b. DATE SIGNED <u>9-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. P. McCarrick</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-16-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Potomac Meth. Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Potomac, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG. STRAR <u>DATE</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12979

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (f outside corporate limits write RURAL and give nearest town) Takoma Park		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MD. b. COUNTY Montgomery c. CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 1300 Milestone dr.	
3 NAME OF DECEASED (Type or print) First Middle Last Albert Minor Linkous		4 DATE OF DEATH Month Day Year September 14 66	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-10-1903
9 AGE (in years last birthday) 63 yrs.		10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repairman		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11 BIRTHPLACE (County & State or foreign country) Roanoke Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Minor Linkous		14 MOTHER'S MAIDEN NAME Lena Wills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 225-05-1618	
17 INFORMANT Mrs. Elsie G. Linkous		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion D.E. TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) D.E. TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 8, 1955 , to Aug. 21, 1966 , that (I) (we) lost the deceased alive on Aug. 21, 1966 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a SIGNATURE Russell B. Arnold M.D.		22b. DATE SIGNED 9/14/66	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d. ADDRESS 1106 Spring Street, Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Interment	23b DATE THEREOF 7/17/66	23c NAME OF CEMETERY OR CREMATORY Green Hill Cem.	23d LOCATION (City or Town) (County) (State) Lanham Md.
24. FUNERAL DIRECTOR See Will & Burial & Cremation		ADDRESS	
25a REC'D BY REGISTRAR SEP 20 1966		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camp etely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12980

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 4802 Creek Shore Drive	
3 NAME OF DECEASED (Type or print) First Elsie Middle Beatrice Last LOVE		4 DATE OF DEATH Month September Day 29 Year 19 66	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 21, 1893
9 AGE in years (last birthday) 73 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (Country & State or foreign country) New York City, N.Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME August Bukmaier		14 MOTHER'S MAIDEN NAME Mary Rathgeb	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no N/A		16 SOCIAL SECURITY NO 100-24-5820	
17 INFORMANT Rockville Address Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS WITH MASSIVE OF METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (t) (this hospital) attended the deceased from Sept. 19, 1966 , to Sept. 29, 1966 , that (t) (we) last saw the deceased alive on Sept. 29, 1966 , and that death occurred at 8:15 P.M. from causes on and the date stated above.			
22a. SIGNATURE <i>J. E. Davis</i>		22b. DATE SIGNED 30 Sept. 1966	
22c. PHYSICIAN'S NAME (Type) J. E. DAVIS LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMAINS (Specify)	23b. DATE OF DEATH 10/4/66	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Hawthorne, New York
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR DATE 10/4/66	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12981

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived first institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7010 Pyle Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle C Last Loveless		4. DATE OF DEATH Month September Day 4 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 17, 1891
9. AGE In years (last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Schlatt		14. MOTHER'S MAIDEN NAME Catherine Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOC. A. SECURITY NO 215-24-5081	
17. INFORMANT Mrs. Mary Kay - Dtr. - Same as #2		Address	
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arterial Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Fibrosis DUE TO (c) Carcinoma of Colon		INTERVAL BETWEEN ONSET AND DEATH months year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 22, 1966 , to Sept 2, 1966 , that (I) (we) last saw the deceased alive on Sept 4, 1966 , and that death occurred at 1 P.M. , from causes and on the date stated above			
22a. SIGNATURE Lyle Williams M.D.		22b. DATE SIGNED Sept 4, 1966	
22c. PHYSICIAN'S NAME (Type) Lyle Williams		22d. ADDRESS 831 University Blvd E. Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/7/66	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem	23d. LOCATION (City or Town) (County) (State) Silver Spring Md
24. FUNERAL DIRECTOR JOS GAWLER'S SONS, 5130 WIS. AVE. NW, WASH, D.C.		25. REC'D BY REGISTRAR SEP 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12982

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Germantown 16 years

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Home

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

e. STATE

Maryland

f. COUNTY

Montgomery

g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Germantown - Rural

h. STREET ADDRESS

i. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Stonestreet

Middle

William

Last

Fubin

DATE OF DEATH

September

Month

Day

Year

1966

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Oct - 17 - 1908

9. AGE (in years)

57 yrs

IF UNDER 1 YEAR

Months Days Hours M. N.

11 23

10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman on County Road

10b. KIND OF BUSINESS OR INDUSTRY

Montgomery County

11. PLACE OF BIRTH

Potomac, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George Washington Fubin

14. MOTHER'S MAIDEN NAME

Amelia May Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

213-01-1825

17. INFORMANT

Agnes B Fubin, Route 1, Germantown, Md.

Address

18. CAUSE OF DEATH (Enter on only one cause per line for a, b, and c)

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE

Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

2 hours

CONDITIONS, if any which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

(b)

DUE TO

(c)

Cardiac Myocardia

1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY (Month, Day, Year)

Hour a.m. p.m. 19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

County

State

21. I certify that (I) (this hospital) attended the deceased from Sept - 12 - 1966 to Sept - 24 - 1966, that (I) (we) last saw the deceased alive on Sept - 24 - 1966, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

William C. Miller

M.D.

ATTENDING PHYSICIAN

☒

MED. DIRECTOR

☐

STAFF PHYSICIAN

☐

22b. DATE SIGNED

Sept - 24 - 1966

22c. PHYSICIAN'S NAME (Type)

WILLIAM C. MILLER, M.D.

22d. ADDRESS

7-Brooks Ave., Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

9-25-66

23c. NAME OF CEMETERY OR CREMATORY

Monocacy

23d. LOCATION (City, town or county)

Beallsville, Mont.

(State)

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Francis H. Barber

ADDRESS

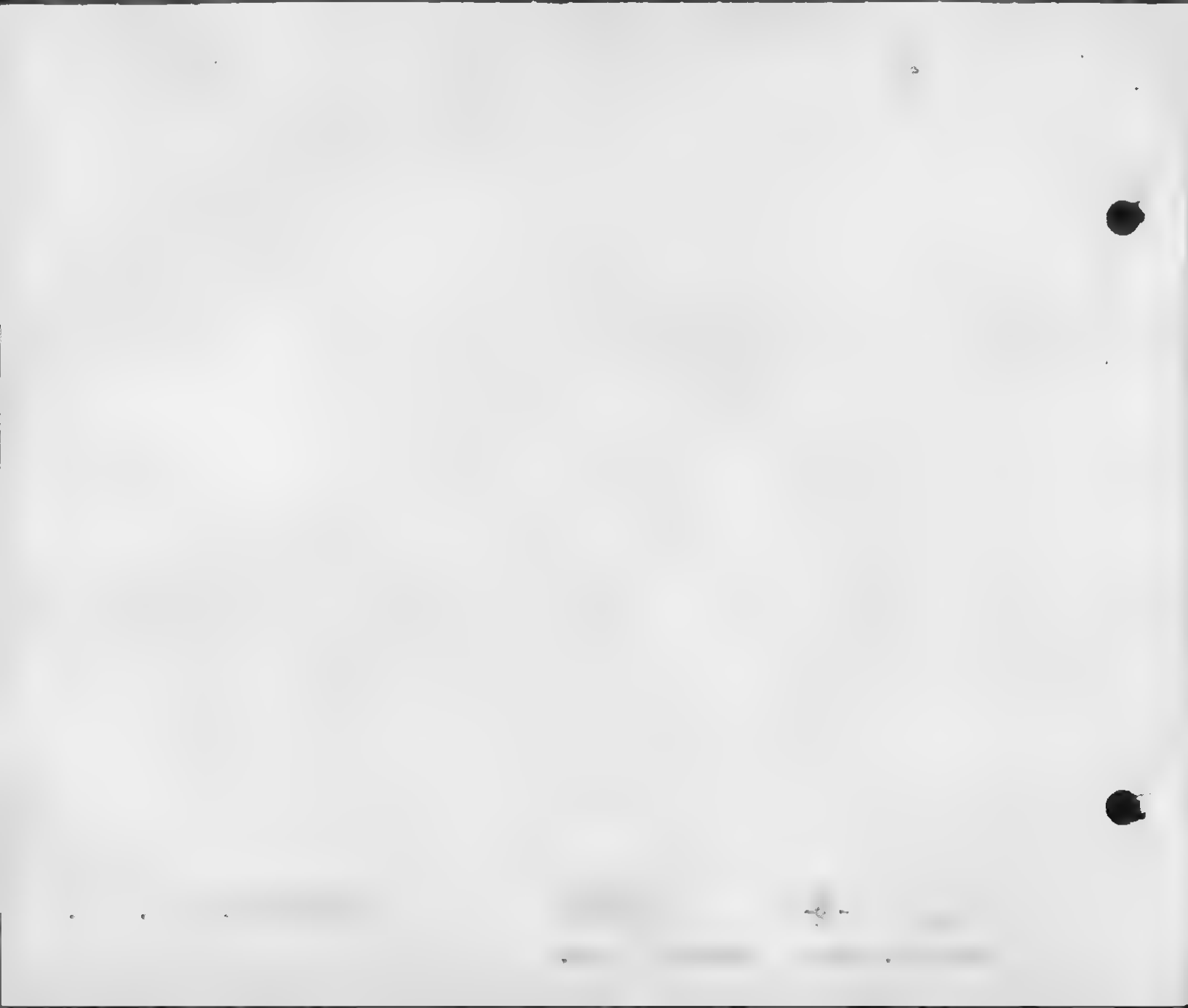
Laytons, Md.

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

SE



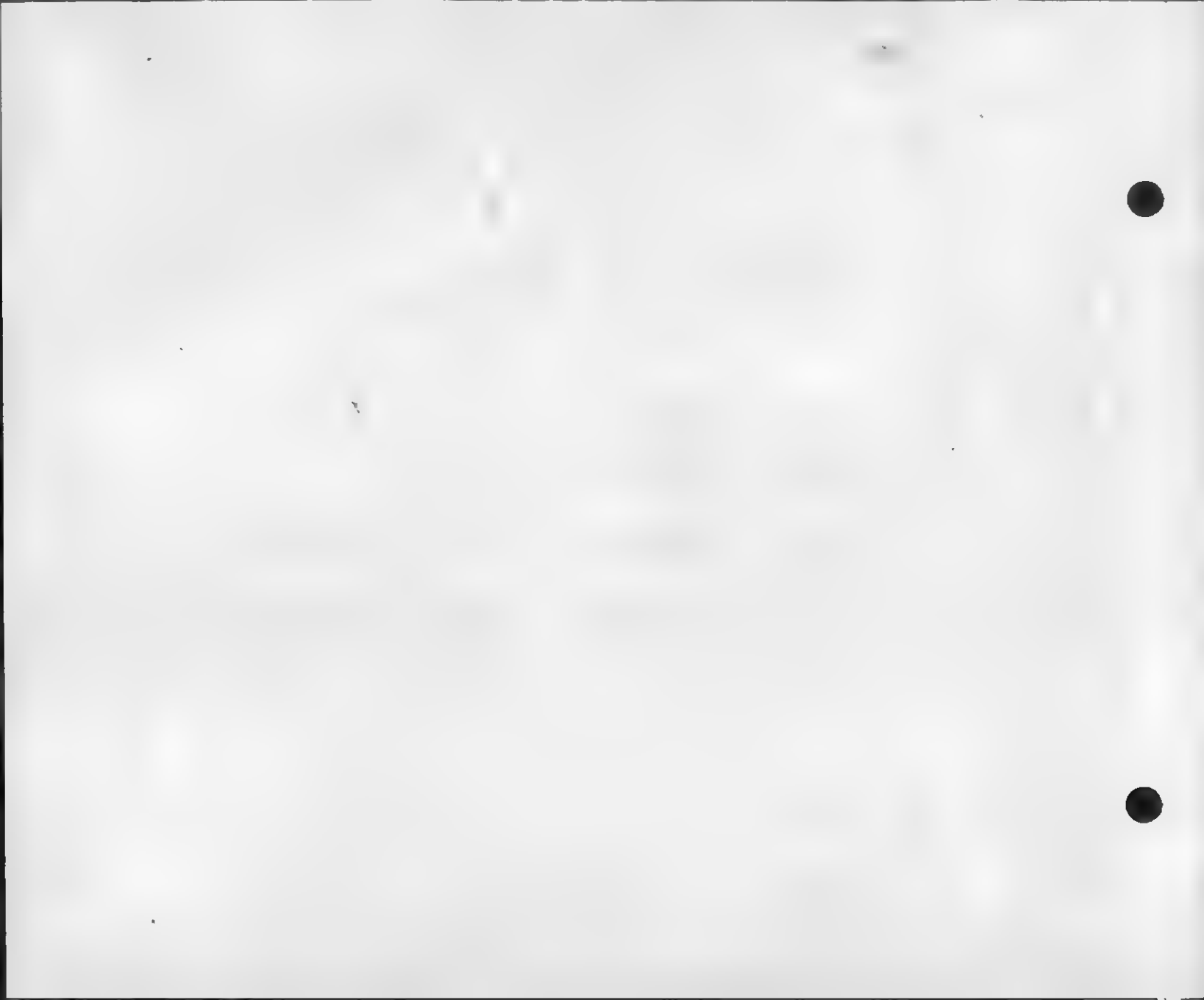
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12983

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 yrs 3 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Oakview Dr</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>5204 Westwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carlotta</u> First Middle Last <u>Lukins</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 19, 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Russell</u>		14. MOTHER'S MAIDEN NAME <u>Amarillis Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>57960 4998</u>		17. INFORMANT <u>Betty Didcott</u> Address <u>5204 Westwood Dr. Wash. D.C. 20016</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertension, Cerebral</u> DUE TO (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH <u>unkn.</u> <u>11 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Secondary</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 11, 1966</u> to <u>Sept. 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 31, 1966</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Sept. 11, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. [Signature]</u>	
22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			
23b. DATE THEREOF <u>9-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Paulk Son Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>SEP 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

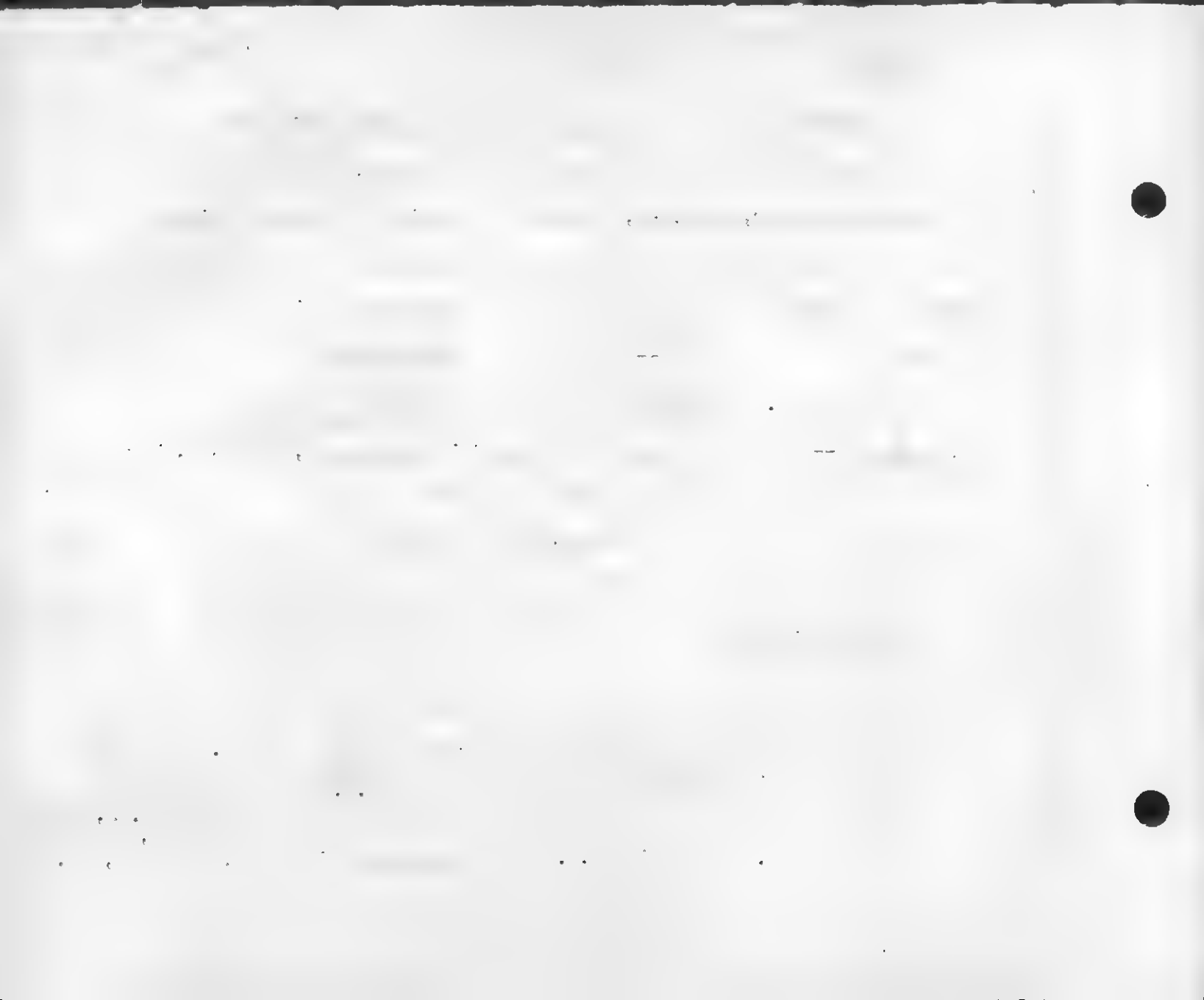


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chapel Hill		
c. LENGTH OF STAY IN 1b 128 Days			d. STREET ADDRESS 313 West University Drive		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Loudon Last MacFadyen			4. DATE OF DEATH Month September Day 4 Year 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 April 1947	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Loudon E. MacFadyen			14. MOTHER'S MAIDEN NAME Violet Ornsby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address The Medical Records The Clinical Center, Bethesda, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Proteus Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphoblastic Leukemia DUE TO (c) Renal Insufficiency					INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Insufficiency					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 April , 19 66 , to 4 Sept. , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 September 19 66 , and that death occurred at 8:45M , from the causes and on the date stated above.					
22a. SIGNATURE <i>Joel J. Rubenstein</i>		A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. ATTENDING PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 4, 1966	
22c. PHYSICIAN'S NAME (Type) Joel J. Rubenstein, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 8/5/66	23c. NAME OF CEMETERY OR CREMATORY Chapel Hill Mem. Park		23d. LOCATION (City, town or county) (State) Orange Co. N.C.	
24. FUNERAL DIRECTOR The S. L. Pines Co 2901-14th. St. N.W. D.C.		25a. REC'D BY REGISTRAR SEP 3 1966		25b. REGISTRAR'S SIGNATURE <i>W. J. Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

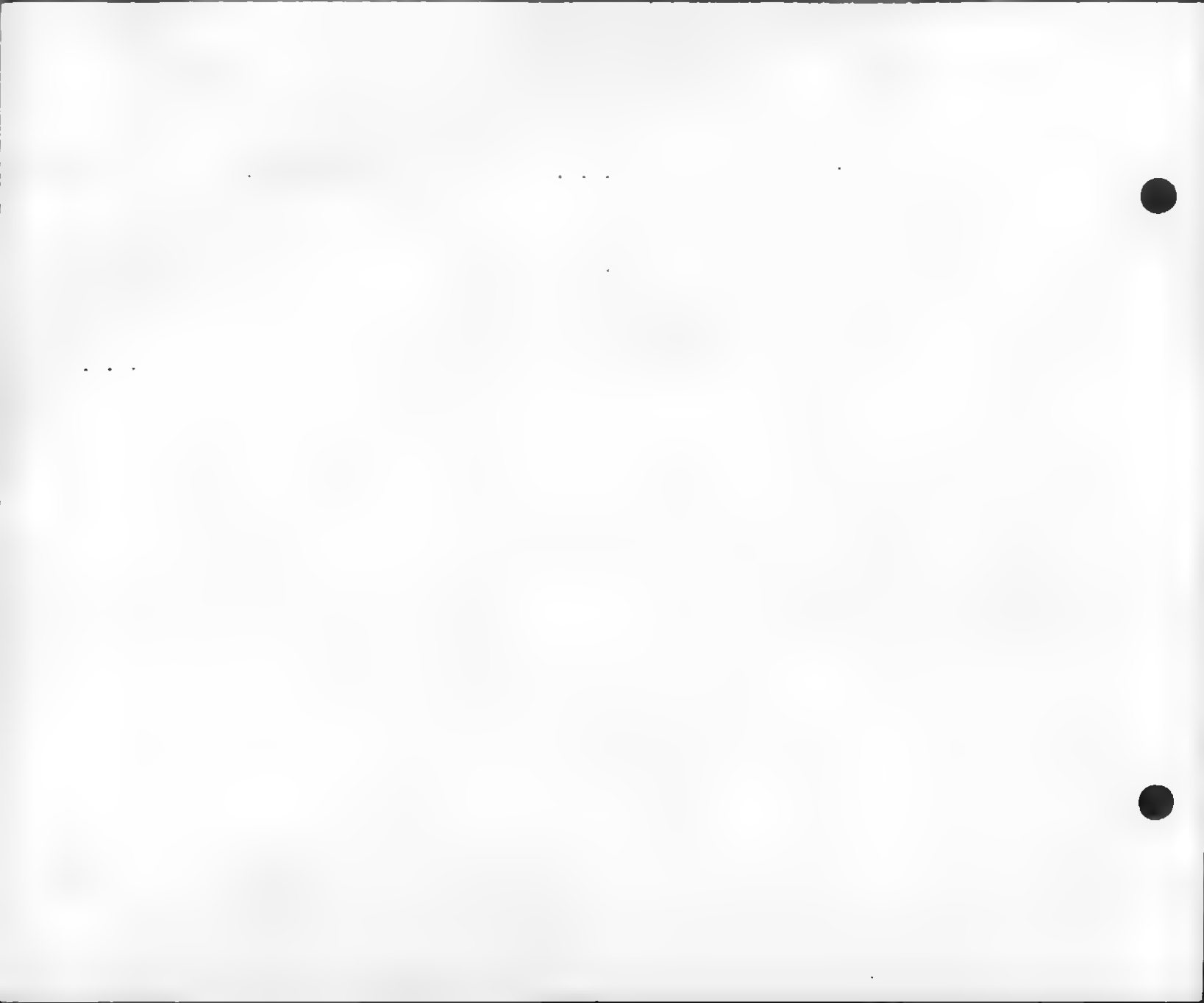
VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12985

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN Silver Spring		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN Rockville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d STREET ADDRESS 4713 Tallahassee Ave.	
3 NAME OF DECEASED First John Middle G. Last Madden		4 DATE OF DEATH Month Sept Day 4 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug 15, 1910
9 AGE Years 56 Months 0 Days 0 Hours 0 Minutes 0		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	
10b KIND OF BUSINESS OR INDUSTRY Lockheed Aircraft		11 BIRTHPLACE (State or foreign country) Washington, D. C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME John Madden	
14 MOTHER'S MAIDEN NAME Alice Lee Gaither		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None	
16 SOCIAL SECURITY NO 579-03-7990		17 INFORMANT Mrs. Medora Pelican Sister: 4713 Tallahassee Ave, Rockville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line or (a), (b), or (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21a TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		21b INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
21c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21d (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Sept. 5, 1966	
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, & county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Sep. 10, 1966	23c NAME OF CEMETERY OR CREMATORY Val Halla Memorial Park	23d LOCATION (City or town) (County) (State) Monterey, California
24 FUNERAL DIRECTOR Clark E. Wison Warner E. Pumphrey, Inc.		25a REC'D BY REGISTRAR SEP 13 1966 25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12986

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY in 1b <u>20 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Res. before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>4848 Chevy Chase Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Lila</u> Middle <u>Marie</u> Last <u>MAKI</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 CO OR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>June 24, 1907</u>
9 AGE in years (last birthday) <u>59</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>		10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>LABOR RELATIONS BOARD U.S. GOV'T.</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Finland</u>		11 BIRTHPLACE (County & State or foreign country) <u>Finland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>UNKNOWN MAKI</u>	
14 MOTHER'S MAIDEN NAME <u>Edna HYONANEN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO <u>- - -</u>		17 INFORMANT <u>Daughter - ELIZ. NYE - SAME AS #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aneurysm, ruptured, rt. internal carotid artery</u> (b) <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>	20f (City or town) (County) (State) <u> </u>
21 I certify that (I) (this hospital) attended the deceased from <u>8-31</u>, 19<u>66</u>, to <u>9-11</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>9-16</u>, 19<u>66</u>, and that death occurred at <u>3:15</u> AM, from causes and on the date stated above.			
22a SIGNATURE <u>Francis J. Gable Jr. M.D.</u>		22b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Gable Jr. M.D.</u>		22d ADDRESS <u>2218 Wisconsin Ave. Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b DATE THEREOF <u>9-19-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	23d LOCATION (City or Town) (County) (State) <u>SCITLAND MD.</u>
24 FUNERAL DIRECTOR <u>JES GANLER'S SONS</u>		25a REC'D BY REGISTRAR <u>SEP 20 1966</u>	
25b REGISTRAR'S SIGNATURE <u>James Judge</u>		25c ADDRESS <u>513 WISCONSIN AVE, N.W. WASHINGTON D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12987

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in or residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN <u>Bethesda</u> c Outside corp. limits, write RURAL and give nearest town.		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Shriners</u>		d STREET ADDRESS <u>2413 Pershing</u>	
3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>E</u> Last <u>Martin</u>		4 DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-11-1880</u>
9 AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Trenton, N.J.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Lee Martin</u>		14 MOTHER'S MAIDEN NAME <u>?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>508-10-1000</u>	
17 INFORMANT <u>Son</u>		Address	
B CAUSE OF DEATH (Enter or y one cause per (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia</u> DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) <u>Benign Prostatic hyperplasia - obstructed</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yrs</u> <u>4 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable Myocardial Infarction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/1966</u> to <u>9/6/1966</u> , that (I) (we) last saw the deceased alive on <u>9/6/1966</u> , and that death occurred at <u>11:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert K. Macdon</u>		22b. DATE SIGNED <u>9/7/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE <u>SEP 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

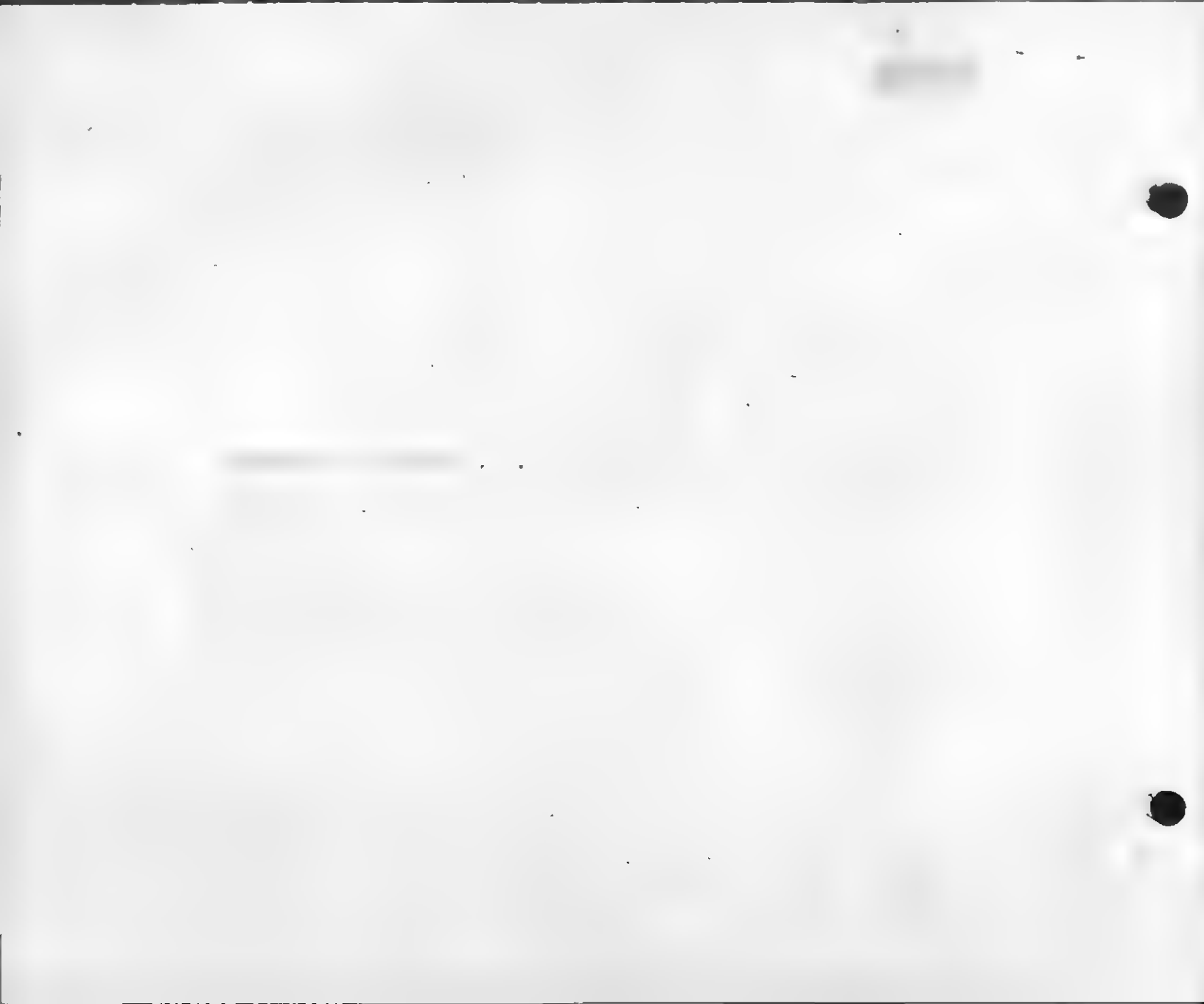
1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12984

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived first prior to residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>7 DAYS</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>5616 CEDON RD.</u>	
3 NAME OF DECEASED (Type or print) <u>L. Frances C. MATTINGLY</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-23-1894</u>
9 AGE (in years last birthday) <u>72 yrs</u>		IF UNDER 1 YEAR Months Days Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>BETHESDA Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles C. Bohrer</u>		14 MOTHER'S MAIDEN NAME <u>Annie R. Hodges</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>217-32-2172H</u>	
17 INFORMANT <u>R. L. Mattingly - husband - same item #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-hrs</u> <u>4 yrs</u> <u>10 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia, urine retention, dehydration</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>RAILROAD</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 19, 1954</u> , to <u>9/7, 1966</u> , that (I) (we) last saw the deceased alive on <u>9/6, 1966</u> and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above			
22a SIGNATURE <u>Charles Savarese, MD</u>		22b DATE SIGNED <u>9/7/66</u>	
22c PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE, MD</u>		22d ADDRESS <u>1125 Rockville Pike, Rockville, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>9/9/66</u>	<u>Rockville</u>	<u>Rockville Montg. Md.</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a REC'D BY REG STRAR <u>SEP 8 1966</u>	
25b REG STRAR'S SIGNATURE <u>[Signature]</u>		DATE	



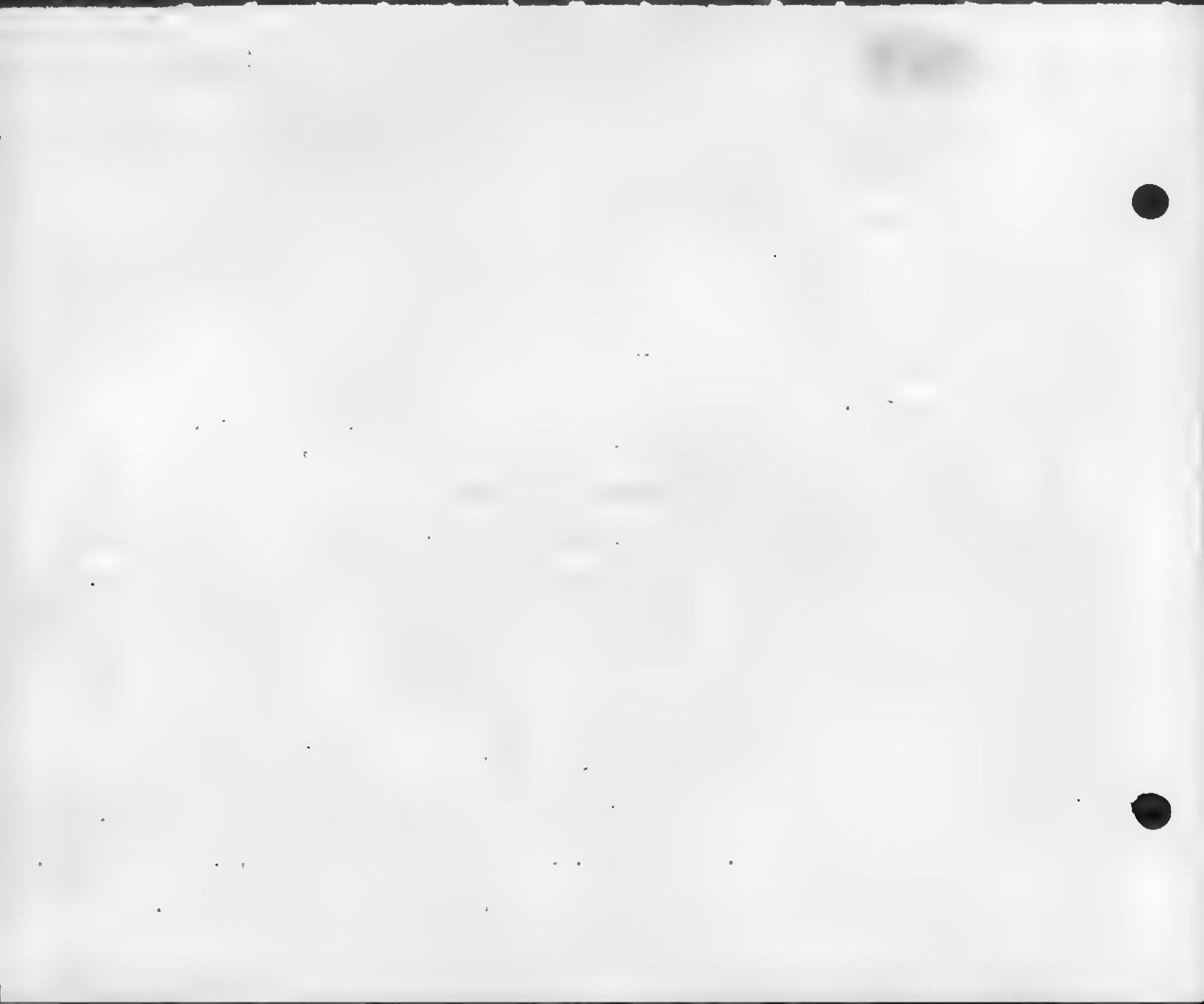
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Item~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>56 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Gaston</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gastonia</u> d. STREET ADDRESS <u>304 West 10th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Barbara (NMN) McArver</u>		4. DATE OF DEATH <u>September 16 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>31 May 1945</u>		9. AGE (In years last birthday) <u>21</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger E. McArver</u>				14. MOTHER'S MAIDEN NAME <u>Helen Hall</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>243-70-0447</u>				17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Septicemia</u> <u>2924</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pelvic abscess from perforated colon</u> DUE TO (c) <u>Aplastic anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 - 5 months</u> <u>17 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that <u>she</u> (this hospital) attended the deceased from <u>22 July</u> , 19 <u>66</u> , to <u>16 September</u> , 19 <u>66</u> , that <u>she</u> (we) last saw the deceased alive on <u>16 September 1966</u> , and that death occurred at <u>11:05 PM</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Leonard H. Brubaker</u> M.D.				ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>17 Sept. 1966</u>									
22c. PHYSICIAN'S NAME (Type) <u>Leonard H. Brubaker, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>				23b. DATE THEREOF <u>9-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gastonia Mem. Park</u>				23d. LOCATION (City, town or county) (State) <u>Gastonia, No. Carolina</u>									
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>SEP 20 1966</u>											



FOR STATE
HEALTH DEPT.

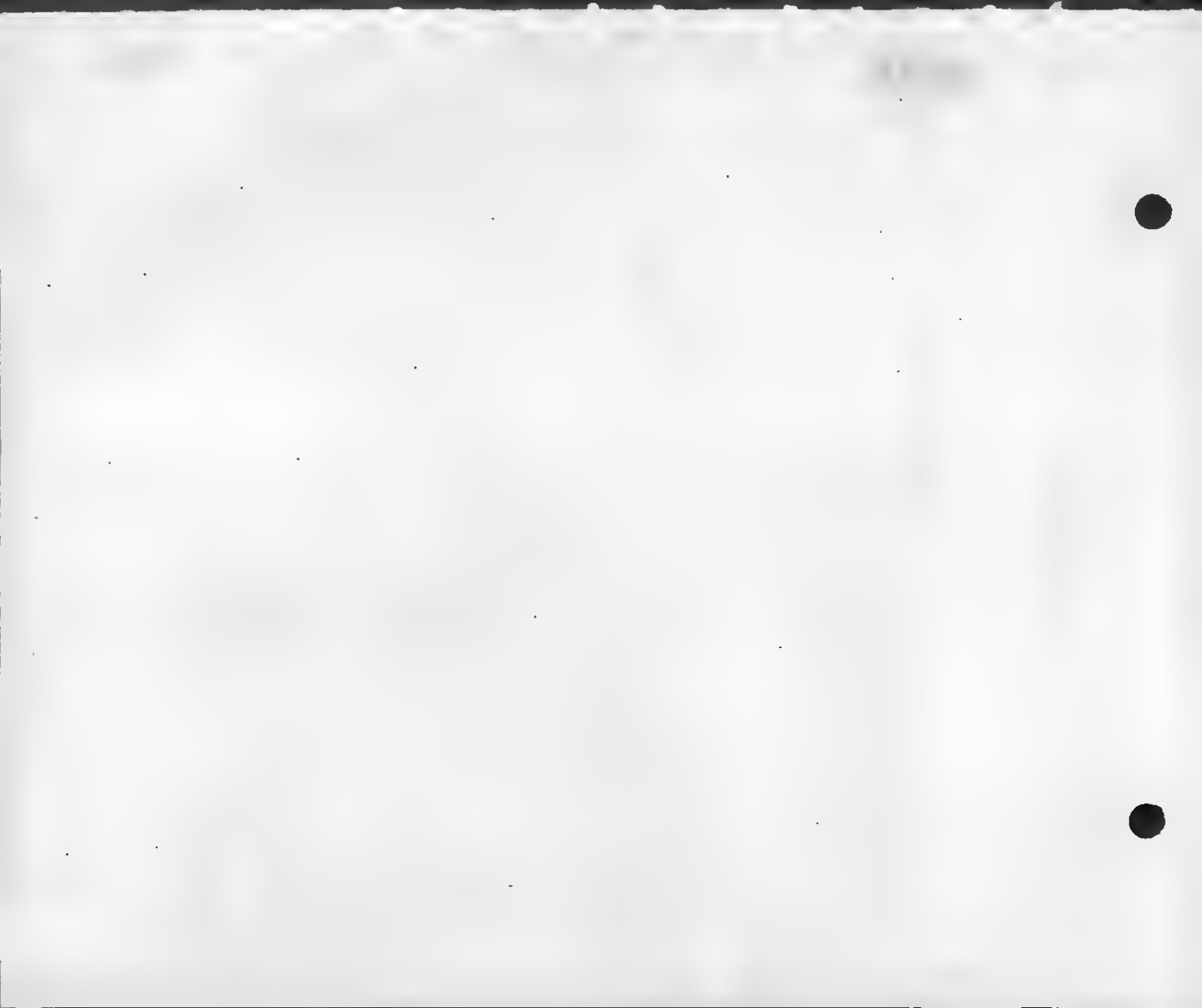
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12950

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9623 Cornell Pl.</u>				e. STREET ADDRESS <u>2010 Kalorama Rd., NW</u>			
3. NAME OF DECEASED (Type or print) <u>Caroline E. McCauley</u>				4. DATE OF DEATH <u>Sept. 5, 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1889</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR <u>77</u> Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>Rolph E. Dittus</u>				14. MOTHER'S MAIDEN NAME <u>Caroline G. Giel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Washington Woods</u> Address <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial inf.</u> DUE TO (b) <u>Chronic myocardial inf.</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Robert Rogers</u> M.D.				22. DATE SIGNED <u>Sept 5, 1966</u>			
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept 5, 1966</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>				23d. LOCATION (City, town or county) (State) <u>Washington</u>			
24. FUNERAL DIRECTOR <u>John S. Rogers</u> ADDRESS <u>None</u>				25a. REC'D BY REGISTRAR <u>SEP 5 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u>			



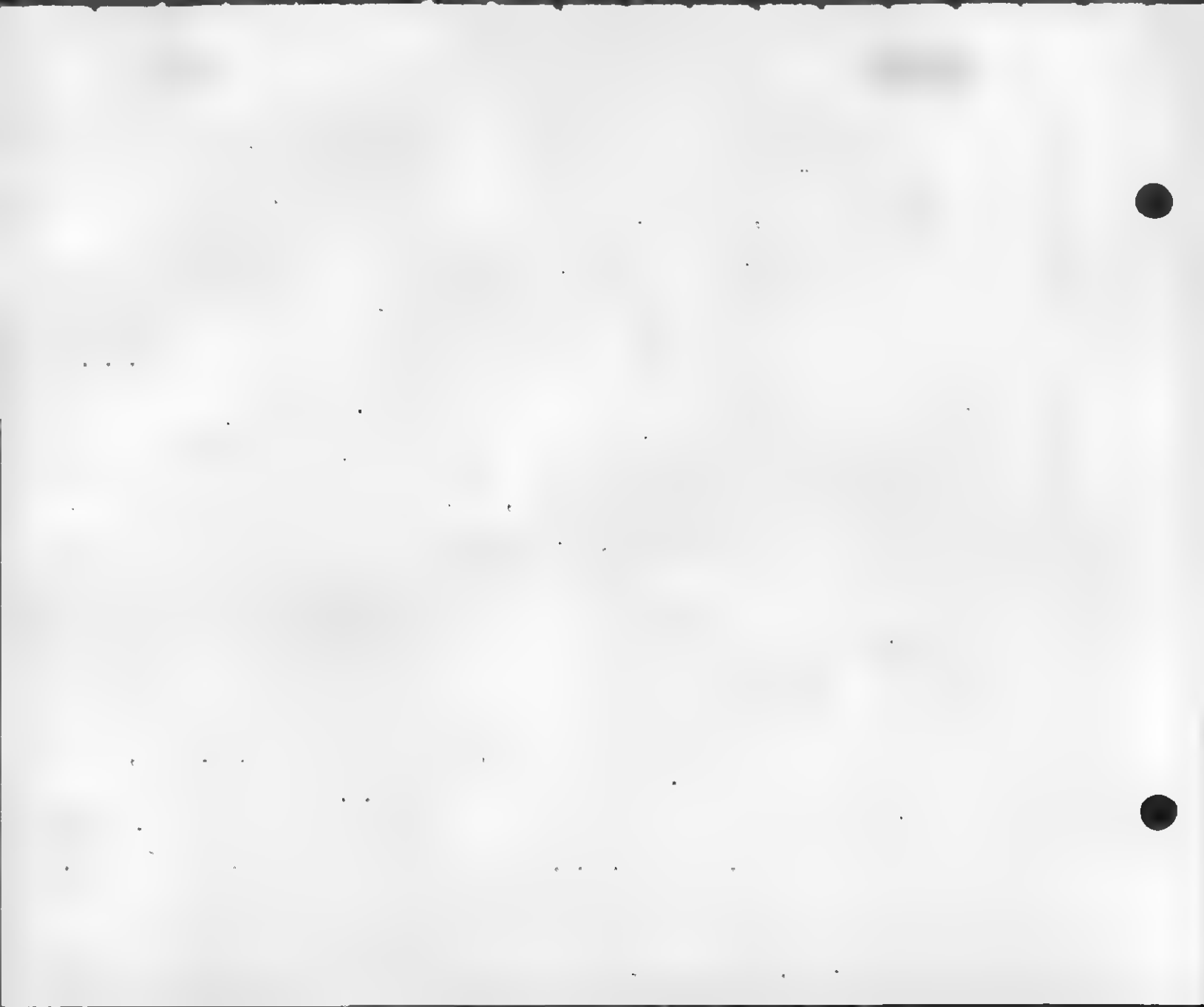
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12991

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Sangamon</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Springfield</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>National Institutes of Health The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>2530 Lowell Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Margaret</u> <u>Ann</u> <u>(none)</u>		4. DATE OF DEATH <u>September 11 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 December 1947</u>
9. AGE (in years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Junior McClain</u>		14. MOTHER'S MAIDEN NAME <u>Marion B. Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leukemia, lymphoblastic</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Meningeal leukemia, impacted right lower wisdom tooth</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>26 July 1966</u> , to <u>11 Sept. 1966</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11 Sept. 1966</u> , and that death occurred at <u>3:45M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard H. Brubaker</u> M.D.		22b. DATE SIGNED <u>Sept. 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leonard H. Brubaker, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 14, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Springfield, Illinois</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles E. Wilson</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		DATE <u>SEP 14 1966</u> <u>J. Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

12992

VR A15ME
6M 1/66



CERTIFICATE OF DEATH

12993

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDUSTEY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U. S. NAVAL HOSPITAL		d. STREET ADDRESS BOX 66	
3. NAME OF DECEASED (Type or print) First Middle Last PRISCILLA (NMN) MERVOSH		4 DATE OF DEATH Month Day Year SEPTEMBER 18 19 66	
5 SEX FEMALE	6 COLOR OR RACE CAUCASIAN	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 JAN 1927
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY NONE	11 BIRTHPLACE (Country & State, or foreign country) PENNSYLVANIA
13 FATHER'S NAME MIKE VUYANOVICH		14 MOTHER'S M AIDEN NAME DOROTHY BASSAR	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO.	
17 INFORMANT SAMUEL MERVOSH		Address BOX 66, INDUSTRY, PENNSYLVANIA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CANCER DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 20 , 19 66 , to SEPT. 18, 1966 , that (I) (we) last saw the deceased alive on SEPT. 18 , 19 66 , and that death occurred at 1:00 PM , from causes and on the date stated above			
22a SIGNATURE <i>Carl Paul Kessler</i> M.D.		22b DATE SIGNED SEPT. 18, 1966	
22c PHYSICIAN'S NAME (Type) C. P. KESSLER		22d ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 21, 1966	23c. NAME OF CEMETERY OR CREMATORY BEAVER CEMETARY	23d. LOCATION (City or Town) (County) (State) BEAVER BEAVER PA.
24 FUNERAL DIRECTOR SCHWERTHA FUNERAL HOME		25a REC'D BY REGISTRAR SEP 20 1966	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12994

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If at home, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>2000 F. ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Meyers</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/94</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>	
11. BIRTHPLACE (County & State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Jacob Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Gertie Farley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES 1917-1919</u>		16. SOCIAL SECURITY NO. <u>493-24-6071</u>	
17. INFORMANT <u>BLANCHE B MEYERS</u>		Address <u>2000 F. ST. N.W. WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a) (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest by anoxia</u> DUE TO <u>Chronic Emphysema</u> DUE TO <u>Chronic Myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>5 yrs</u> <u>3 yrs</u>	
PART I: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>1963</u> to <u>Sept 26, 1966</u> that (ii) (we) last saw the deceased alive on <u>9-23-19</u> , and that death occurred at <u>4:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Clive E Thompson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIVE E Thompson</u>		22d. ADDRESS <u>901 Potomac St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or town) (County) (State) <u>FT MYER VA</u>
24. FUNERAL DIRECTOR <u>WILLIAM CHAMBERS, JR.</u>		25a. REC'D BY REGISTRAR <u>1400 CHAMBERS, JR.</u>	
25b. REGISTRAR'S SIGNATURE <u>WASH DC</u>		25c. DATE <u>SEP 26 1966</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission) a STATE <u>Maryland</u> b COUNTY	
b CITY OR TOWN <u>Takoma Park</u> c LENGTH OF STAY IN 1b		c CITY OR TOWN <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d STREET ADDRESS <u>9209 Dilston Road</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Schriever Middleton</u>		4 DATE OF DEATH Month Day Year <u>9 27 1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-10-24</u>
9 AGE (In years last birthday) <u>42</u> yrs		10 IF UNDER 1 YEAR Months Days	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager Safeway Store</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>America</u>	
13 FATHER'S NAME <u>Albert Middleton</u>		14 MOTHER'S MAIDEN NAME <u>Mary Schriever</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>yes</u> (if yes give war or dates of service) <u>WW-2</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Patient's Chart.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> (b) <u>(metastatic)</u> (c) <u>Proven Washington Hosp Center July 66</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-27, 1966</u> to <u>—</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>66</u> , and that death occurred at <u>10</u> P.M. from causes and on the date stated above			
22a SIGNATURE <u>Gilbert B. Cushman</u> M.D.		22b DATE SIGNED <u>9-27-66</u>	
22c PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHMAN</u>		22d ADDRESS <u>6480 N.H. Ave TK Pt Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>Sept 28, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Greenwood</u>
24 FUNERAL DIRECTOR <u>—</u>		25a REC'D BY REGISTRAR <u>—</u> 25b REGISTRAR'S SIGNATURE <u>—</u>	

Cleared by Medical Examiner
Dr. John Royce

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12996

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
c. LENGTH OF STAY IN lb <u>35 min.</u>		d. STREET ADDRESS <u>1916 Fox Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Milam</u>		4. DATE OF DEATH Month Day Year <u>9 10 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-91</u>
9. AGE (In years, lost birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Adrienne Booth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of serv. ce)		16. SOC. AL. SEC. RTY NO	
17. INFORMANT <u>Miss Eugenia Milam Adelphi, Md.</u>		Address <u>1916 Fox St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute G-I bleeding</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Adenocarcinoma Caecum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Sept 10</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Sept 10</u> , 19 <u>66</u> , and that death occurred at <u>7:58</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>R. H. Sandstrom</u>		22b. DATE SIGNED <u>9-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD.</u>		22d. ADDRESS <u>7701 Carroll Ave. Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 13 - 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Douglass</u>		23d. LOCATION (City or town) (County) (State) <u>Frederick Douglass</u>	
24. FUNERAL DIRECTOR <u>Frederick Douglass</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p align="center">MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH</p>											
<p>1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery</p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney</p>				<p>c. LENGTH OF STAY IN 1b 4 days</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boysds</p>				<p>d. STREET ADDRESS RFD # 1, Box 165</p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital</p>						<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Miller</p>						<p>4. DATE OF DEATH Month Sept. Day 4 Year 1966</p>					
<p>5. SEX Female</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Aug. 15, 1892</p>		<p>9. AGE (In years last birthday) 74 yrs.</p>		<p>IF UNDER 1 YEAR: Months 7 Days 4 Hours 19 Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) Virginia</p>			<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		
<p>13. FATHER'S NAME Thomas W. Jacobs</p>						<p>14. MOTHER'S MAIDEN NAME Amanda Johnston</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No</p>				<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Mrs Ellen M. Birdette,</p>			<p>Address Item 2</p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive (diastolic) Vascular - Renal Disease DUE TO (b) C.H.F. - Acute - due to renal disease DUE TO (c) Chronic Vascular Disease</p>										<p>INTERVAL BETWEEN ONSET AND DEATH 7 days</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (1) (this hospital) attended the deceased from Aug. 28, 1966 to Sept. 4, 1966, that (1) (we) last saw the deceased alive on Sept. 3, 1966, and that death occurred at 2:10 a.m., from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE Jack Schumacher, M.D.</p>						<p>22b. DATE SIGNED 7-6-66</p>			<p>22c. PHYSICIAN'S NAME (Type) Jack Schumacher, M.D.</p>		
<p>22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.</p>						<p>22e. REC'D BY REGISTRAR</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>23b. DATE THEREOF Sept. 7, 1966</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Arlington National</p>		<p>23d. LOCATION (City, town or county) (State) Ft. Myer, Va.</p>			
<p>24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.</p>						<p>25a. REC'D BY REGISTRAR SEP 8 1966</p>					
<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>						<p>25c. REGISTRAR'S NAME Charles Judge</p>					

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12994

1 PLACE OF DEATH a COUNTY <u>Picotgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY N 1b <u>Riverdale</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		d STREET ADDRESS <u>4214 Connecticut Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Cille M. Miller</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-22-1906</u>
9 AGE in years last birthday <u>60</u> yrs		10 UNDER 1 YEAR Months <u>36</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
12 BIRTHPLACE (County & State or foreign country) <u>Texas</u>		13 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14 FATHER'S NAME <u>Frank B. Rhymes</u>		15 MOTHER'S MAIDEN NAME <u>Vines Terry</u>	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war and dates of service) <u>No</u>		17 SOCIAL SECURITY NO <u>457 34 9128</u>	
18 INFORMANT <u>Stis Siant</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Massive metastases to lungs</u> DUE TO (c) <u>Carcinomatous from right breast ca</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>36 hours</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>18 mos</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> to <u>Sept 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 10</u> , 19 <u>66</u> , and that death occurred at <u>10 P.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>W. B. Eastman</u>		22b DATE SIGNED <u>Sept 11, 1966</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>9/14/66</u>	<u>Ft. Lincoln</u>	<u>Colmar Manor P.G. Md.</u>
24 FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a REC'D BY REG STRAR DATE <u>SEP 14 1966</u>	
ADDRESS <u>4735 Bel Air</u>		25b REGISTRAR'S SIGNATURE <u>J. L. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

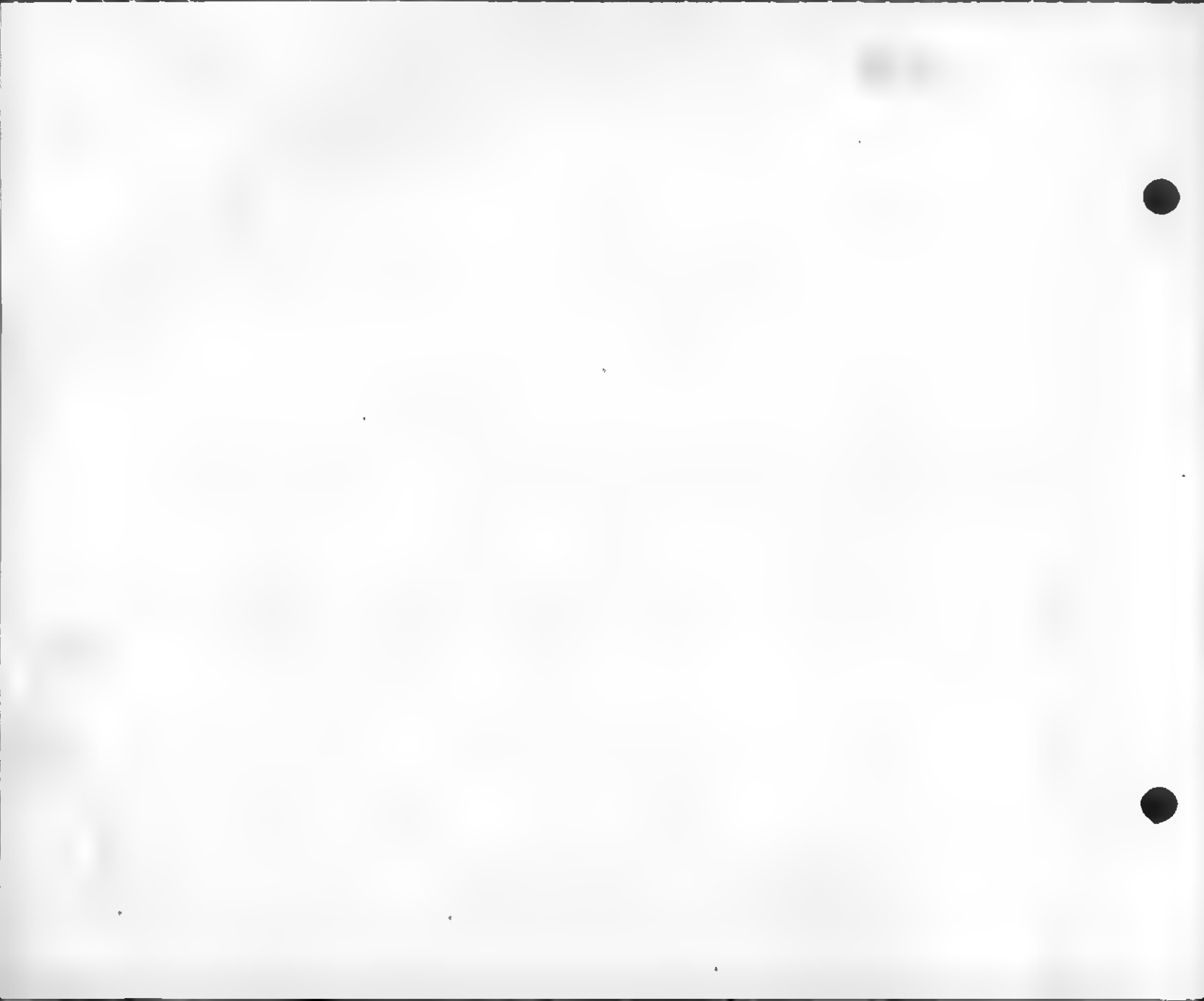
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12999

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN <u>Bethesda</u> c. LENGTH OF STAY IN ID <u>DoA</u> d. NAME OF HEALTH CARE INSTITUTION (if not in hospital) give street address <u>Suburban</u>				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN <u>Comau manner</u> d. STREET ADDRESS <u>4311 Lawrence St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED First <u>Harry</u> Middle <u>Leonard</u> Last <u>Mahlysh</u>				4 DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>1966</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2/23/12</u> 9 AGE <u>49</u> yrs	
10a. OCCUPATION (If work done during most of life, give it, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sub. San.</u>		11 BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harry Leonard Mahlysh</u>				14 MOTHER'S MAIDEN NAME <u>Elsie P. Bell</u>			
15 WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>236-109125</u>		17 INFORMANT <u>Dr. W. Law</u>		18 SIGNATURE OF INFORMANT <u>Richard L Jenkins</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>401X</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>lost</u> (b) <u>lost</u> (c) <u>lost</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>					
21. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		21d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Richard L Jenkins</u> M.D.				22. DATE SIGNED <u>Sept 9, 1966</u>			
EXAMINER'S NAME (year) <u>1915 So. Md. St. L. Mont.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Com.</u>		23d. LOCATION (City or town) (County) (State) <u>Colmar Manor, Md.</u>	
24 FUNERAL DIRECTOR <u>Nalley's</u> ADDRESS <u>Mt. Rainier, Maryland</u>				25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

-MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13000

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN TAKOMA PARK c. NAME OF HOUSE OR INSTITUTE WASHINGTON SAN. & HOSP. d. NAME OF DECEASED HARRY HARVEY MOORE e. SEX MALE f. RACE WHITE g. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> h. DATE OF BIRTH 4-18-04 i. AGE 62 yrs. j. IF UNDER 1 YEAR 22 Mths. 9 Days 66 Years k. IF UNDER 24 HRS 22 Hrs. 9 Mins. l. CAUSE OF DEATH Acute coronary insufficiency m. INTERVAL BETWEEN ONSET AND DEATH n. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION o. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> p. TIME OF INJURY 19 Hour pm q. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work r. PLACE OF INJURY factory street, office bldg. etc. s. (City or town) (County) (State) t. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> u. ACTUAL SIGNATURE Beelden R. Reap MD v. EXAMINER'S NAME BELEDEN R. REAP MD w. ADDRESS 6434 Georgia Ave. Silver Spring, Md. x. 23a. BURIAL (CREMATION) REMOVAL (Specify) Burial y. 23b. DATE THEREOF Sep. 26, 1966 z. 23c. NAME OF CEMETERY OR CREMATORY Burtonsville, Union Cem. aa. 23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland ab. 24. FUNERAL DIRECTOR C. Glen Carter ac. ADDRESS 6434 Georgia Ave. Silver Spring, Md. ad. 25a. REC'D BY REGISTRAR SEP 26 1966 ae. 25b. REGISTRAR'S SIGNATURE [Signature]				2. USUAL RESIDENCE (where deceased lived, if institution. Re: no. to get re-admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN TAKOMA PARK d. STREET ADDRESS 8506 GREENWOOD AVE. #4 e. IF R.S. DEATH ON A FARM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO f. DATE OF DEATH SEPT. 22 1966 g. IF UNDER 1 YEAR 22 Mths. 9 Days 66 Years h. IF UNDER 24 HRS 22 Hrs. 9 Mins. i. CAUSE OF DEATH Acute coronary insufficiency j. INTERVAL BETWEEN ONSET AND DEATH k. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION l. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> m. TIME OF INJURY 19 Hour pm n. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work o. PLACE OF INJURY factory street, office bldg. etc. p. (City or town) (County) (State) q. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> r. ACTUAL SIGNATURE Beelden R. Reap MD s. EXAMINER'S NAME BELEDEN R. REAP MD t. ADDRESS 6434 Georgia Ave. Silver Spring, Md. u. 23a. BURIAL (CREMATION) REMOVAL (Specify) Burial v. 23b. DATE THEREOF Sep. 26, 1966 w. 23c. NAME OF CEMETERY OR CREMATORY Burtonsville, Union Cem. x. 23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland y. 24. FUNERAL DIRECTOR C. Glen Carter z. ADDRESS 6434 Georgia Ave. Silver Spring, Md. aa. 25a. REC'D BY REGISTRAR SEP 26 1966 ab. 25b. REGISTRAR'S SIGNATURE [Signature]			
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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13002

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>DO.A.</u>		2 USUAL RESIDENCE (Where deceased lived for at least 1 year before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Silver Spring</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>		d. STREET ADDRESS <u>8540 - 11th Ave.</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First <u>CHARLES</u> Middle <u>EUGENE</u> Last <u>MYERS</u>		4 DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-12-26</u> 9 AGE in years <u>40</u> last b. day <u>40</u> yrs
10a. BUSINESS OR INDUSTRY <u>Claims adjuster</u>		11 BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Thomas Myers</u>	
14 MOTHER'S MAIDEN NAME <u>Alice McClure</u>		15 WA. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16 SOCIAL SECURITY NO. <u>577 30 4405</u>	
17 INFORMANT <u>Mrs. Helen Myers (wife)</u>		Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute my</u> DUE TO <u>43-1</u> Conditions (any which gave rise to immediate cause (a), stating the underlying cause last) (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month Day Year <u>19</u>	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>9-30-1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u></u> Address (City or town or county) <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>George Hatten, 257 Canal St. & W. 4C</u>		25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u></u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

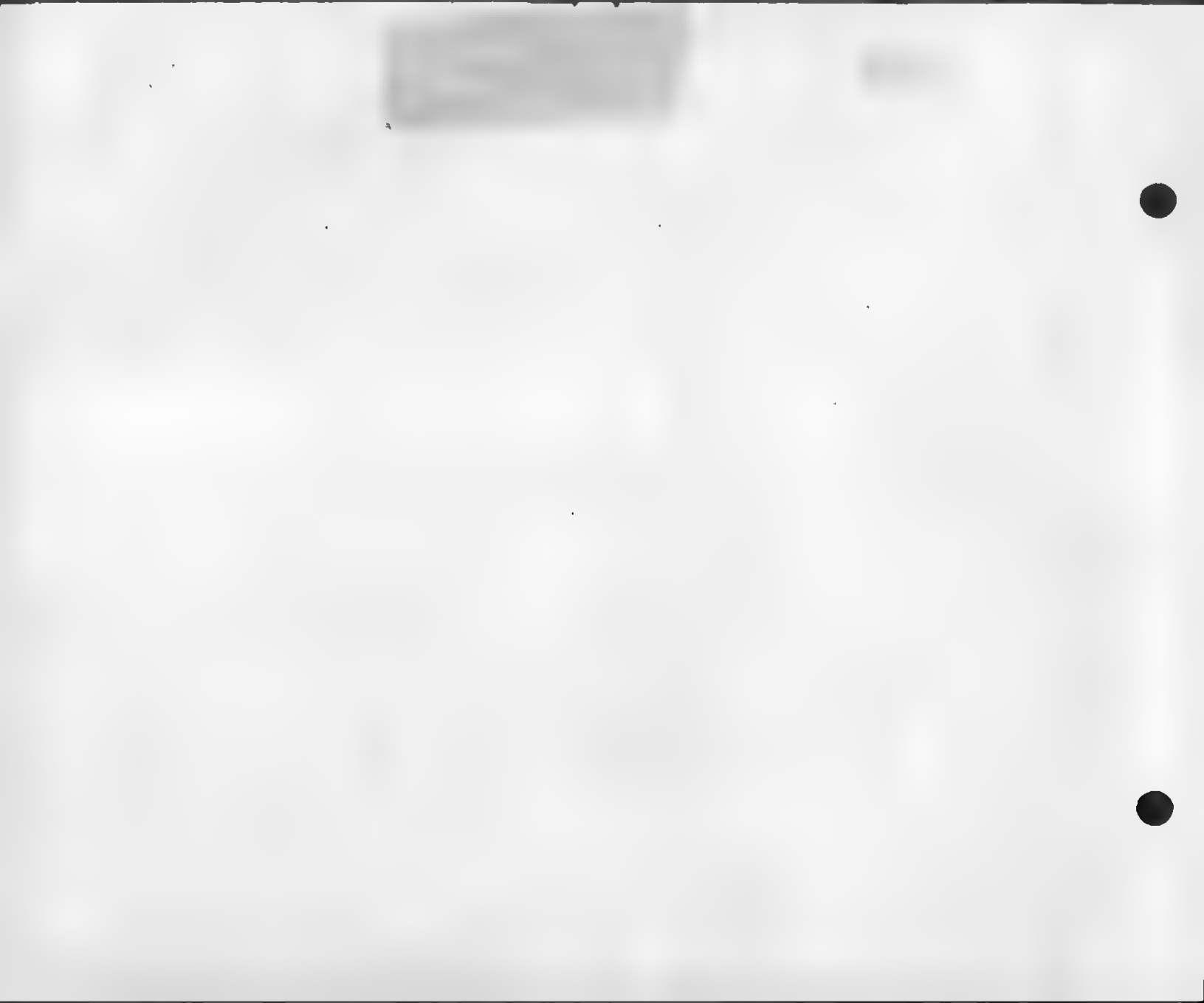
CERTIFICATE OF DEATH

13001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN TB <u>2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>KENSINGTON GARDENS</u>		d. STREET ADDRESS <u>11536 Highview Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>F</u> Last <u>MULLINS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7, 1885</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Goolsby</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Virginia Koontz Wheaton, 11536 Highview Avenue Wheaton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4.2001 Congestive heart failure</u> DUE TO (b) <u>chronic heart disease</u> DUE TO (c) <u>myocardial arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1966</u> to <u>Sept 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 6, 1966</u> , and that death occurred at <u>6:42 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Dr Joseph P. Henrich</u> M.D.		22b. DATE SIGNED <u>9, 7, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr JOSEPH P. HENRICH</u>		22d. ADDRESS <u>6455 Rockledge Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>	23d. LOCATION (City or town) (County) (State) <u>Inscalosa, Alabama</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphreys</u>		25a. REC'D BY REG. STRAR DATE <u>SEP 12 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>22 days</u>		d. STREET ADDRESS <u>1221 Garland Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>(NMN)</u> Last <u>Pelton</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-05</u>
9. AGE (in years last birthday) <u>60</u>		10. IF UNDER 1 YEAR Months <u>60</u> Days <u>00</u> Hours <u>00</u> Min. <u>00</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. COUNTRY OF BIRTH (County & State or foreign country) <u>Maryland</u>		13. COUNTRY OF BIRTH (County & State or foreign country) <u>Maryland</u>	
14. FATHER'S NAME <u>Harry Johannes</u>		15. MOTHER'S M maiden name <u>Elna Klanting</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>Washington San & Hosp Record - Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of gall bladder</u> DUE TO <u>1966</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1966</u> DUE TO (c) <u>1966</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County, (State)
21. I certify that (I) (the hospital) attended the deceased from <u>8-13</u> , 19 <u>66</u> , to <u>9-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-4</u> , 19 <u>66</u> , and that death occurred at <u>2:50</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u> M.D.		22b. DATE SIGNED <u>9-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 University Blvd. E., Suite Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept 7-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Mary's</u>
24. FUNERAL DIRECTOR <u>St. Mary's Mort., 254 Chas. St. N.W.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
ADDRESS <u>St. Mary's Mort., 254 Chas. St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the ward pending in pencil in item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit (File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13004

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Montgomery			
b CITY OR TOWN Silver Spring write RURAL and give nearest town				c CITY OR TOWN Takoma Park write RURAL and give nearest town			
d NAME OF HOSPITAL OR INSTITUTION Holy Cross Hospital write street address				d STREET ADDRESS 505 Tulip Avenue			
3 NAME OF DECEASED (Type in print) Henrietta E. New				4 DATE OF DEATH Month 9 Day 28 Year 66			
5 SEX F		6 COLOR OR RACE W		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 20, 1879	
9 AGE 87 year(s) 8 month(s) 0 day(s)		10 IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		11 BIRTHPLACE (State or foreign country) Morrisville, Penna.		12 "N" OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Abraham E. Hamilton				14 MOTHER, MARDEN NAME Margaret June Morris			
15 ADDRESS OF DECEASED (If in institution, give name of institution) at home				16 SOCIAL SECURITY NO 731-84547			
17 INFORMANT William F. New				18 ADDRESS OF INFORMANT 731 Basley Street Silver Spring, Md.			
19 CAUSE OF DEATH (Enter cause per line for 1, 2, or 3) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4.001 DUE TO (b) cardiac tamponade (c) cardiac tamponade Conditions if any which gave rise to immediate cause (a), stating the underlying cause							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS A CPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month 10 Day 1 Year 1966 Hour 11 or p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> or <input type="checkbox"/> at home <input type="checkbox"/>		20e PLACE OF INJURY (Home farm factory street office bldg. etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.				22. DATE SIGNED 9-28-1966			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER William F. New Address (Street, city, county, or country)			
23a BURIAL, CREMATION, or other disposal Burial		23b DATE THEREOF Oct. 1, 1966		23c NAME OF CEMETERY OR CREMATORY National Memorial Park		23d LOCATION (City or town) (County) (State) Falls Church, Virginia	
24 FUNERAL DIRECTOR Arthur Watters ADDRESS 254 Capitol St. N.W. Washington, D.C.				25a REC'D BY REG. STRAR 001		25b REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

13011

13005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hagerstown</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>	
c. LENGTH OF STAY IN 1b <u>14 days/12 hrs.</u>		d. STREET ADDRESS <u>Hartford St., Franklin Manor</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Garess</u> Middle <u>NMN</u> Last <u>Nicony</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-94</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR, Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Nicony</u>		14. MOTHER'S MAIDEN NAME <u>John L. Licon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>154-12-7011</u>	
17. INFORMANT Address <u>Hospital Records 7600 Carroll Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>MO</u> <u>YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anterior carcinoma of bladder with metastases</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 22, 1966</u> to <u>Sept 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 2, 1966</u> , and that death occurred at <u>6:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.		22b. DATE SIGNED <u>9/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, MD</u>		22d. ADDRESS <u>1106 SPRING ST SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept 6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Howland</u>	23d. LOCATION (City or Town) (County) (State) <u>Howland</u>
24. FUNERAL DIRECTOR <u>John J. Grollman</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

13002

13001

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3

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

13012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13006

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>D.O.A.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San & Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i> d. STREET ADDRESS <i>12300 Middle Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Maria Ondrejko</i>		4. DATE OF DEATH Month Day Year <i>9 - 25 - 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-24-16</i> 9. AGE (In years last birthday) yrs <i>49</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Netherlands</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nicholas Zirkzee</i>		14. MOTHER'S MAIDEN NAME <i>Mary VanDenreiden</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No None Yes</i>		17. INFORMANT <i>John M. Ondrejko - HUS.</i> Address <i>12300 Middle Rd., Wheaton, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Acute coronary insufficiency</i> (b) <i>Coronary artery heart disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		22. DATE SIGNED <i>9-25-1966</i> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sep. 29, 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>
24. FUNERAL DIRECTOR <i>Glen Carter</i> <i>Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>SEP 30 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

P-25-40